Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) SKINNER OUISE 1:25 AM FEB 27 04 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Days Hours 1 ☐ M 2 10 220.14.4686 Usual Residence of Decedent 10b. County 10c. City, Town or Location BATTIMORE 1 No MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2023 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Curan, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Specify: BLACK 1 Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry PHONE DPERATOR HOSPITAL Coltege (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a Informant's Name/Relationship (Type Print) .

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. , or Itams 23a or 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "netural; or Itams 23a or 28a-f show any joury or other traumatic event, the Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

\_Physician

/Medical

**Funeral Director** 

Be Completed by

10a. State

Examiner

**Funeral** 

Director

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director.

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

ţ.

emoval from State	cometery, crematory of the Maunital No.	or other place)	.3.04 B	Timore	MAR-ILAN
2 Grue	22. Name	and Address of Facility VA	BACTIMOR	E. MARN	INERAL HO LAND 212
ations that caused the dea cause on each line.	th. Do not enter the n	node of dying, such as cardia	c or respiratory arrest,		Approximate Intervat Between Onset and Death
SEPSIS					
Due to (or as a consec	quence of):				
		10NIA			
Due to (or as a consec	quence of):				
Due to (or as a consec	quence of):				
			926		
1 Live birth 2 Fet	al death 3 □Ectopid		~	23d. Date of de Month	i <b>very</b> Day Year
ributing to death but not re-	sulting in the underlyin	g cause given in Part I.			the cause of death?
				prior to death?	utopsy findings availab completion of cause of
		26. Place of De	ath (Check only one)		
ospital: 1 npatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 TResidence	6 TOther (Spe	cifv)
28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?			
28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fac	tory, office			ural Route Number,
er: On the basis of examination	owledge, death occurr ation and/or investigat	ed at the time, date and plaction, in my opinion, death occ	e, and due to the cause surred at the time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
and manner stated.					
and manner stated.		29c. License number	29d. [	Date signed (Mont	h, Day, Year)
3	cations that caused the dealer cause on each line.  Due to (or as a consect ASPIRATION	cemetery, crematory of KING MALIAN CONTROL OF STATE OF ST	Existing the death. Do not enter the mode of dying, such as cardial end cause on each line.    SEPS   Secure of pregnancy   1   Live birth   2   Fetal death   4   Pregnant at time of death   5   Other (specify)   9   Unknown   1   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing   28a. Date of Injury (Month, Day Year)   28b. Time of Injury   M   1   Yes   2   No   28b. Place of Injury - At home, farm, street, factory, office   10   10   10   10   10   10   10   1	emoval from State    Commeterly, crematory or other place	comelery, crematory or other place)  LINE MANDEM TARK 3.3.04 BATTIMPLE,  22. Name and Address of Facility Way In C. GLEENE FOR LAND SATTIMPLE, MREY  actions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line.  SEPSI  Due to (or as a consequence of):  Cityes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 5   Other (specify)  Pregnant at time of death 5   Other (specify)  Stributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to 1   Yes 2   No 3   Prediction of the prior to death 1   Yes 2   No 2   No 3   Prediction of the prior to death 2   Yes 2   No 3   Prediction of the prior to death 3   Yes 2   No 3   Prediction of the prior to death 3   Yes 2   No 3   Prediction of the prior to death 3   Yes 3   Yes 3   Yes 4   Yes 4

of person who completed cause of death (ttem 23a) (Type, Print) GILBERT BOURTEILY, MD

,5601 WICH RAVEN BLUD, BALTIMORE, MDZ1239

DHMH 17 Rev 1/2001

State Registrar

SAMARITAN

TAL

			State of Mary a,27,PerME,G829	,3/23/04eg	rtificate o	f Death	2. Date of Deat		0650 3. Time of Death
Physici:	an	Decedent's Name (First, Middle, Li			-	7	Month	Day Y	ear
/Medic	al	Michael  4a. Facility Name (If not institution, gi	Lee	;		nders , or Location of Death	rebrua	ry 23, 2	
Examin	er	2854 Garrison Av			Baltim			40. Godiny Gr	Doda"
Funeral	No.			yrs. last birthday)	If Under 1 Ye		8. Date of Birth	Voor) 9	Birthplace (State or Foreig
Director		214-88-9075 Usual Residence of Decedent	1X M 2□F 36	Yrs.	Months Day	Hours Min.	(Month, Day,		MD
natural', or items 23a or 28a-f ehow Algal Exacitres rount be notified at		10a. State 10b. County		c. City, Town or Lo					10d. Inside City Limits 1 XYes 2 □ No
"natural", or items 23a or 28a-f ehow splical Exaniner must be notified at	Funeral Director	MD NA	E	Baltimor					
or 28	Dire	10e. Street and Number			10f. Zip Code	9	1	0g. Citizen of Wh	at Country?
238	60	2854 West Garr				21215		U.S	
tems er m	une	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Origin? (Sp uban, Mexican, Puerto	ecity Yes or No- Rican, etc.)		American Indian, White, etc.
o i	by F	X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 h	lo Specify:		Specify:	Black
tural	be b	15. Decedent's 8		16a Dece	dent's Usual Oc	cupation		16b. Kind of Busi	
Silver	Completed	(Specify only highest g	ade completed)	(Give	kind of work do DO NOT use ret	ne durina most of work	ina	orest	
other than 'vent, the Ms	E	Elementary/Secondary (0-12)  12th grade	College (1-4or 5+) na	Lá	and Sca	per		Golf Co	urse
item 27 is marked other than other traumatic event, the M	Be C	17. Father's Name (First, Middle, Las				18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	
is marked of raumatic eve	To B	John Franklin				Delore	s Rando	olph	
E E		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Stre	et and Number or Rur	al Route Number	City or Town, St	ate, Zip Code)
important: it ite any injury or of once.	7. 3	21. Sonat re of Funeral Service Lico 23a. Pakti. Enter the disease, or coshock, or heart failure. List only	inplications that caused the yone cause on each line.	2	1300 Wa	T/H West abash Ave	Balti or respiratory arre	more M	d 21215 Approximate Interval Between Onset and Death
ician dical niner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	onsequence of):					
	miner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of):					
rial-trans	Exa	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):					
ng physician and as the burial-transit	edicai	•	<b>d</b>						
o to	an/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregna □ Other <i>(specify</i>		120007	23d. Date Monti	
attendir for use	hysic	3 CHRIOMII		of resulting in the I	andarhina anuan	given in Part I.	23e. Did tot	acco use contrib	ute to the cause of death?
igned by the attendir be detached for use	ed by Physician/M	Part II. Other significant conditions	contributing to death but n	ot resulting in the c			1 □ Ye	es 2 🗓 No 3	☐ Probably 4 ☐Unknow
has been signed by the attendir je 2 should be detached for use	eted by		contributing to death but n	or resulting in the c	indenying cause		24a. Was a autops perforr	n 24b. We y pri ned? de	Probably 4 Unknown ere autopsy findings available or to completion of cause of ath? Yes 2 No
ate has been signed by the attendir page 2 should be detached for use	þ		Į	or resulting in the c		26. Place of Deal	24a. Was a autops perform	n 24b. We pring de 2 No 12	ere autopsy findings available or to completion of cause of ath?
s certificate has been signed by the attendir director, page 2 should be detached for use	e Completed by	Part II. Other significant conditions  25. Was case referred to medical examiner?  1⊠ Yes 2 □ No	Hospital: 1 ☐ Inpatient	2 □ ER/Outpatie	nt 3 DOA	Other: 4 Nursing Ho	24a. Was a autops perform 1 X Yes a h (Check only on ome 5 \( \text{Reside} \)	n 24b. We pring de 20 1) September 1) September 24b. We pring de 20 1) September 24b. We pring de 20 1) September 24b. We prince 24b. We prin	ore autopsy findings available or to completion of cause of auto?  Yes 2 \( \sum \) No  (Specify) At SCEDE
ate has been signed by the attendir page 2 should be detached for use	Be Completed by	Part II. Other significant conditions 25. Was case referred to medical examiner?	Hospital:	2 □ ER/Outpatie	nt 3□ DOA	Othos	24a. Was a autops perform 1 X Yes 2	n 24b. We pring de 20 1) September 1) September 24b. We pring de 20 1) September 24b. We pring de 20 1) September 24b. We prince 24b. We prin	ore autopsy findings available or to completion of cause of auto?  Yes 2 \( \sum \) No  (Specify) At SCEDE

30. Name and

29c. License number

29d. Date signed (Month, Day, Year) February 24, 2004

O.C.M.E.

State Registrar

31. Date filed (Month, Day, Year)

2004

32. Agistrar's Signature

address of person who controlled cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

(If not institution, give  KINS BAYNE  Number 6. Se	a street and number)  W MALI (A) CO  EX 7. Age (In yrs.  58  10c. Ci  12. Was Decedent Ever in L  Armed Forces?  1	Ass birthday) Yrs. ity, Town or Lo Bal	Baltiv If Under 1 Year Months Days	or Location of Dea	8. Date of Birt (Month, Day 1-19-	Day Yea 2-7 1-00 4c. County of De NA 7. Year) 9. 8	4- 3:25 AM
Number 6. Se 1034 of Decedent NA NA umber renton Ave 15. Decedent's Edecity only highest graceondary (0-12)	7. Age (In yrs. 58 10c. Ci	Ass birthday) Yrs. ity, Town or Lo Bal	If Under 1 Year Months Days  ocation timore  10f. Zip Code 21206	If Under 24 Hrs	(Month, Day 1-19-	9. B (, Year) -45 S	10d. Inside City Limits
mber renton Ave. mied 2 Married 4 Divorced 15. Decedent's Edecity only highest gracecondary (0-12)	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Bal	timore 10f. Zip Code 21206				
rried 2 Married 4 Divorced  15. Decedent's Edecify only highest gracecondary (0-12)	12. Was Decedent Ever in U Armed Forces? 1   Yes 2 No If Yes, Give Year or Dates:	-	21206				
rried 2 Married  4 Divorced  15. Decedent's Educify only highest gracecondary (0-12)	Armed Forces?  1	-	If Yes specify Cub	Jisaania Origin? (	Specify Ves or No-	10g. Citizen of What USA	Country?
ecity only highest grad condary (0-12) grade	lucation		1 ☐ Yes 2½ No		no Rican, etc.)	Specify:	Black
First, Middle, Last)	de completed)  College (1-4or 5+)	(Give	edent's Usual Occup a kind of work done DO NOT use retire Bank Tel	during most of wo d)	orking	16b. Kind of Busines Bank	:s/Industry
	Sell			Agle		Gamble	
Name/Relationship (T) Segar   Isposition 2   Cremation 3   1 5   Other (Specify	Husband 20b.	3806	osition (Name of omatory or other pla	Ave., B	altimore, Date	nr. City or Town, State , Md. 212 20c. Location - City  Randalls	06 or Town, State
Funeral Service Licens	plications that caused the dea			'.H. East	1101	imore, Md. E. North	21202 Ave . Approximate Interval Between
e (Final tion tion conditions, immediate dearlying or injury tis b) Last	a. Muth System  Due to (or as a conse  b. CVA and  Due to (or as a conse  c. Myonic h  Due to (or as a conse  d. Essential t	aduence of):  Auto equence of):  Aptivate plumate of):	rior M aguabh				2. au i.c
ent pregnant 12 months? 2 □ No wn	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3[	□Ectopic pregnanc □ Other (specify) _	ey		23d. Date of o Month	delivery Day Year
nificant conditions co MSION, ba	contributing to death but not re	esulting in the u	underlying cause g	ven in Part I.	23e. Did to	res 2 No 3□	e to the cause of death?  Probably 4 Unknow
				00 81	1 ☐ Yes	prior prior death	
No eath 5 Pending	28a. Date of Injury (Month, Day Year)	-	of 28c. Inju	her: 4 Nursing ury at ork?	Home 5 Resid	dence 6 Other (S	pecify)
6 Could not be determined	building, etc. (Spec	cify)			City or Tow	wn, State)	
Certifying Ph 2 Medical Exan	hysician: To the best of my kr miner: On the basis of examir and manner stated.	nowledge, dea nation and/or ir	investigation, in my	opinion, death oc	curred at the time,	date and place, and o	due to the cause(s)
	completed cause of death (Its	em 23a) (Type					·
t	ath 5 Pending investigation 6 Could not be determined  Certifying Ph 2 Medical Examidities of certifier	ath  5 Pending investigation 6 Could not be determined  28a. Date of Injury (Month, Day Year) 28b. Place of Injury At building, etc. (Spe	Ath  ath  5 Pending investigation  6 Could not be determined  1 Place of Injury (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Time Injury 28c. Place of Injury - At home, farm, so building, etc. (Specify)  1 Certifying Physician: To the best of my knowledge, decay medical Examiner: On the basis of examination and/or and manner stated.	Ath Spending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  1 Certifying Physician: To the best of my knowledge, death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.  29c. Licer Res  dress of person who completed cause of death (Item 23a) (Type, Print)  Soffing Johns Hopkins Baynew Medical	Ath Spending investigation   28a. Date of Injury (Month, Day Year)   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No   1   Yes 3   Yes 4   Yes 4   Yes 5   Yes 6   Yes 6   Yes 7   Yes 7   Yes 7   Yes 8   Yes 8   Yes 8   Yes 8   Yes 8   Yes 9   Yes 9	arred to medical  No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Cher. 4 Nursing Home 5 Residuals Residu	arred to medical

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29, 2004 Month February рМ **Physician** Shampo 8:55 Margarete L. /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1□M all 220-34-9143 81 Feb. 18, Germany Director Usual Residence of Decedent 10d. fnside City Limits the Maryland 10c. City, Town or Location 10a. State 10h County or items 23a or 28a-f show 1∏Yes 2□No the Medical Examiner must be notified at Director MD Prince George's Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with t #232 14625 Baltimore Avenue 20707 U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. art! If tem 27 is marked other than "natural; or tile ury or other fraumatic avent, I'm Medical Examinan 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify Completed by 3 X Widowed 4 Divorced White Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Psychiatric Nurse Substance Abuse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johannes Ziegler Margarete Azzalino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy L. Shampo Laurel, Maryland 20707 daughter 14625 Baltimore Ave. #232 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any njury or West Arundel Crem. 3/2/2004 Odenton, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonardson Funeral Home, P.A. /M01103 313 Talbott Avenue Laurel, Maryland 20707 Kinice 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure weeks /Medical Due to (or as a consequence of) **Examiner** Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Error Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 Other (specify) P.O. I detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Tes 2 No 3 Probably 4 Unknown Aortic Stenosis Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Mitral Regurgitation 24a. Was an , page 2 s autopsy performed? 2**₩** No Renal Insufficency 1 Yes 1 Yes certificate 2√ No Division of Vital To the Hospitel or Attending Physician: within 24 hours after death. funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 2 1 ☐ Yes 2X No 3 DOA 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Medical Certification: After aspitel c.
4 hours after dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only onel and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cert 0 March 2, 2004 , M.D. D35217 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Jackson, M.D. 11055 Little Patuxent Pkwy. #210 Columbia, MD 21044 31. Date filed (Month, Day, Year)
MAR 0 2 2004 32. Registrar's Signature State Registrar

		For State Registrer	State of Maryl	and / Depa <i>Cer</i>	artment of H tificate of L	ealth and M Death	ental Hygi	ene g. No. 2004	06505
Physicia	_	1. Decedent's Name (First, Middle, Last)  TVAN STOY	ANOV				2. Date of Death Month	Day Year <b>27 2004</b>	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give st Howard County Gene	eral Hospit		Columb			4c. County of Death Howard	
Funeral Director		5. Social Security Number 6. Sex 142-68-9964  Usual Residence of Decedent	M 2□ F 7. Age (In 8	yrs. last birthday)  1  Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Mar. 12	Year) 9. Birth Cor.	place (State or Foreign Intry) SSIA
death with the Maryland ms 23a or 28e-f show	tor	10a. State 10b. County MD Howard	100	City, Town or Lo Fulton	cation				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
with the ta or 28e	Director	10e. Street and Number 7560 Pindell School	ol Road		10f. Zip Code 2075	9	10	g. Citizen of What Cou USA	untry?
should be filed within 72 hours after death with the Marylan Manial Hygiene. marked other than "natural", or Items 23a or 28e-f show matic event, the Madical Examinar mast be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever Armed Forces? 1 Yes 2X No			spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
within 72 hours ene. than "natural", re Modical Ex.	Completed by	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	lurina most of worki		6b. Kind of Business/l	ndustry
d 2 should be filed with and Mental Hygiene (? Is marked other that traumatic event, Ital	Be Com	12th 17. Father's Name (First, Middle, Last)	5	Econo	mist	18. Mother's Name		University Maiden Sumame)	y Library
2, 5 a a a	인	Ivan Dmitry  19a. Informant's Name/Relationship (Type Aleksander Stoyanov			•	Unkr and Number or Rura School Roa	al Route Number,	City or Town, State, Z	ijp Code) 0 7 5 9
1 an 1 an 1 eal 1 eal		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ▼ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	emoval from State	Ob. Place of Dispo cemetery, crea	esition (Name of matory or other place	1 .	Date 2	Oc. Location - City or	Fown, State
permit. Pages 1 ar Department of Hea Important: If item any injury or other		21. Signature of Funeral Service License		22	2. Name and Addres	s of Facility DOI	naldson	Funeral Hor , MD 20707	
Pnysician		23a. Part 1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the cause on each line.						Approximate Interval Between Onset and Death
death certificate be executed BY	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conduction of the conduction of	MYOP	thy	- 1 4			years
death certifi e attending ed for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic pregnancy ∃ Other (specify)			23d. Date of deli Month	very Day Year
The law requires that the de ate has been signed by the a page 2 should be detached f	þ	Part II. Other significent conditions con	tributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.		acco use contribute to s 2 □ No 3 □ Pro	the cause of death?
The law requate has been page 2 should	Completed						24a. Was ar autopsy perform 1 Yes 2	y prior to d	topsy findings available completion of cause of
or Attunding Physicien: The law requires tater death.  Sincerdear, After this certificate has been signe in by the funeral director, page 2 should be a	To Be	27. M nn of Death 1 atural 5 ☐ Pending	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time of Injury	f 28c. Injur Wor	4 Li Nursing no		nce 6 □Other (Spec	cify)
To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st Specify)		-	28f. Location (Str. City or Town	reet and Number or Ru , State)	ral Route Number,
To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier 1 Certifying Phys	sician: To the best of moner: On the basis of exa and manner stated.	ımination and/or in	h occurred at the tire	ne, date and place, pinion, death occur	and due to the ca red at the time, da	luse(s) and manner as ate and place, and due	stated. to the cause(s)
To th withir To th	Ň	29b. Signature and title of certifier	1-Mb	eputy	29c. Licens			Peb 26	
		30. Name and address person who co	30	(Item 23a) (Type,	Print)	one Wa	y Ellica	Febzer Huty mi	24042
Sta Regist		31. Date filed (Month, Day, Year) MAR 0 2 2004	32. Registrar's		W				

Physician /Medical Examiner	Decedent's Name (First, Middle,			of Death	1.5.5.4.5		04 0650
	Ronald V  4a. Fecility Name (If not institution,	incent Slater	4b. City, T	own, or Location o	2. Date of D Month Februa	Day Ye	4 1:00P h
Funeral	851 Derby Farms 5. Social Security Number 217-52-4138 Usuel Residence of Decedent	Road 3. Sex 10 M 2 □ F  7. Age (In yrs. last.	birthday) If Under 1	evern Year   If Under 2 Days   Hours	Min. (Month, D	Anne A irth lay, Year) 9. 9, 1948	runde1 Birthplece (State or Foreig Country) Maryland
Maryland -f show liked at	10a. State 10b. County  Maryland Anne A		wn or Location Severn				10d. Inside City Limit
ges 1 and 2 should be fited within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, its Medical Evaniner mant to inclined at or other traumatic event, its Medical Evaniner mant to inclined at To Be Completed by Funeral Director	10e. Street and Number 851 Derby Farm 11. Marital Status 1□ Never Married 2気 Marrie 3□ Widowed 4□ Divorced	12. Was Decedent Ever in U.S. Armed Forces? d 1 fg Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2	21144 ent of Hispanic Original Sylvanic Mexican No Specify:	in? (Specify Yes or N Puerto Rican, etc.)	Specify:	States American Indian, White, etc.
permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or that ery injury or other traumatic event, Its Medical Examina once.  To Be Completed by Fur	15. Decedent's (Specify only highest Elementary/Secondary (0-12)  12th  17. Father's Name (First, Middle, L	grade completed)  College (1-4or 5+)	life. DO NOT use	done during most retired)  Service	of working 's Name (First, Middl		ess/industry
and 2 should be alth and Mental n. 27 is marked our traumatic every traumatic events and the second	Vincent Lew 19a Informant's Name/Relationshi Virginia S. Hum	p (Type, Print) 1 phrey/ Wife 8	351 Derby	Street and Number Farms Ro	ad Severn	th East ber, City or Town, Sta , Maryland	te, Zip Code)
permit. Pages 1 a Department of Hee Important: If Item eny injury or othe pnce.	20a. Method of Disposition 1	3 □Removal from State Epiph ecify) Chur	of Disposition (Nami tery, crematory or off any Episco ch Cemeter 22. Name_and	pal 3	/3/2004	20c. Location - City Odenton, Crematory	Maryland
es that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit by Physician/Medical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (usease) or injury that initiated events resulting in death) Last	a.  Due to (or as a consequence)  Due to (or as a consequence)  C.  Due to (or as a consequence)  d.	ce of):	ner			12 Mon
the death certificate dby the attending physolached for use as the physolached for Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dec 4 Pregnant at time of death 9 Unknown				23d. Date of Month	f delivery Day Year
	Part II. Other significant condition	ns contributing to death but not resultin	g in the underlying ca	use given in Part I.			te to the cause of death?  Probably 4 Gunknov
as b					per	formed? deat	e autopsy findings availat r to completion of cause o h? Yes 2□ No
ng Phyeician: tter this certifu ineral director. on; To Be	25. Was case referred to medical examiner?  1	(Month, Day Year)	D. Time of 28 Injury M	Other: 4 Nu	28d. Describe	sidence 6 Other (so how injury occurred	Specify) or Rural Route Number,
To the Hospitel or Attendivitin 24 hours after death. To the Funeral Director: A completely filled in by the funeral Medical Certificati	(Check only 2 Medical E	Physician: To the best of my knowled xaminer: On the basis of examination and manner stated.	and/or investigation,	in my opinion, deal	h occurred at the time	, date and place, and	due to the cause(s)
NX	30, Name and address of person v	who completed cause of death (Item 23)  Acres 305 (2004)  32: Registrar's Signature	a) (Type, Print)	l Drive	Glen Bi	mily	MD 27061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06507 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William R. Seeburger enurary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Commons Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) MAR 31, 19 Birthplace (State or Foreign Country) **Funeral** 1□M 2□F **Director** 218**-**14-0285 Mary land 79 1924 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "netural", or Items 23e or 28e-f show other treumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ₹ No Maryland Baltimore Catonsville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6118 Regent Park Road 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Namied Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other them any injury or other treumstic event, If a M. Vice President Finance Finance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Seeburger Rosa Rathgaber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Charlene Knod/Daughter 204 Hilton Avenue Catonsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【\*\*Cremation 3 ☐ Removal from State \*\* 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 3-1-04 Baltimore, MD 21. Signature of Funeral Service Licensee

Thomas Gregor 0 <sup>22</sup> Name and Address of Facility Cremation Society of 299 Frederick Road poce MDInc. Baltimore. 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pro **Physician** 0 /Medical Due to (or as a consequence of): **Examiner** ta, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 🗌 Yes 2 🗆 No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2. No or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ို 2,**⊠** No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural death. 1 Tes 2 No 2 Accident completely filled in by the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide the Hospitel 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud NOCA 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAR 0 2 2004

DHMH 17 Rev 1/2001

FERRUARY

SMITH

ORIGINAL

		For State Registrar	State of	of Marylar				ealth a Death	and M		giene Reg. No.	200	14 06	509
Physic	ian	1. Decedent's Name (First, Middle, La.	st)							2. Date of De Month	ath Day	Yea		M
/Med	ical	ROSE SCHNEIDER  4a. Fecility Name (If not institution, give	street and nu	mber)		4b. City	Town, or	Location o		FEBRUAI		County of De		P. M
Exami	ner	UNION HOSPITAL	3.733, 2.73	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ELKI						CIL		
Funera Director		5. Social Security Number 6. S	ex □ M <b>※XX</b> F	7. Age (In yrs.	last birthday) 88 <sup>Yrs.</sup>	If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da JAN • 7	ıy, Year)		irthplece (State of Country) RYLAND	r Foreign
ite, IVIAI ylatifu Z I Z I D-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Medical Examiner must be notilised at	Funeral Director	10a. State 10b. County  MARYLAND CECIL  10e. Street and Number  61 ALGONQUIN ROAD  11. Marital Status	Armed F	NO	RTH EA	ST 10f. Zi 219		ispanic Oriç n, Mexican	gin? (Spe I, Puerto F		JNITE OF AM	zen of What of D STAT IERICA 14. Race - An Black, Wi	res	
hours aft tural; or	þ	1 Never Married XX Married 3 Widowed 4 Divorced	1 □Yes If Yes, G Year or I	ve	16a. Dece	1 ☐ Yes		Specify:				Specify: Will and of Busines	HITE	
within 72 iene.	Completed	(Specify only highest gra Elementary/Secondary (0-12) 12th	de completed,	1-4or 5+)	(Give life.	kind of wi DO NOT L	ork done d ise retired	during most	t of workin	ng		IN HOM	ŕ	
should be filed within a Montal Hygiene. I marked other than Immatic event, the Montal Hygiene.	To Be C	17. Father's Name (First, Middle, Last, ALECK SCHNUCK						18. Mothe	er's Name	(First, Middle	Maiden			
F, WICH Y		19a. Informant's Name/Relationship ( LOUIS A. SCHNEIDE)		AND)	19b. Mailir	•				Route Numb	er, City or	Town, State	, Zip Code)	
Pages 1 and the first of Height of H		20a. Method of Disposition  1X_Neurial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specif	Removal from	State 20b. F	Place of Disponentery, creations PA	osition (Na matory or	me of other plac	e)   N	1ARCH 2004			·	or Town, State  MARYLAN	D
Dailling permit. Pages Department of Importent: If I any injury or once.		21. Signature of Funeral Service Licer		1200						ON PAR WILKEI IMORE,	K FUI NS AV MARY	NERAL 'ENUE 'LAND '	HOME 21229	
Physician /Medical Examiner		23a. Pan Farer the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that one cause on	caused the deal each line. The Coras a consection of the coras a consection of the coras a consection of the coras and the cora									Approximate Interval Betwoen and D	ween
wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consection of the con	quence of):	(	/						1da	- 17
the death certifically the attending phythe attending phyched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	itcome of pregni birth 2 Feta nant at time of c nown	al death 3	⊒Ectopic p ⊒ Other (s					2	3d. Date of o	*	'ear
tuires that a signed build be deta	by	Part II. Other significant conditions	contributing to	leath but not res	sulting in the u	inderlying	cause give	en in Part I.					to the cause of de	
The larate has	Completed											24b. Were prior to death		available tuse of
ystcian: The is certificate director, pag	) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2□	] ER/Outpatier	-t 200	OA Othe	ar.		(Check only only one 5 ☐ Resi				
a Ph er th eral	tlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date (Moi		28b. Time o Injury		28c. Injun Worl		2	8d. Describe			gecny)	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Alte completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Ptac	e of Injury - At h ling, etc. (Speci	ome, farm, sti	reet, facto	ry, office	· · · · · · · · · · · · · · · · · · ·	2	8f. Location ( City or To			Rural Route Numi	ber,
ne Hospil n 24 hour ne Funera pletely fille	edical	29a. Certifier 1 Certifying Processing Check only one)	niner: On the I	e best of my kno casis of examina nner stated.	owledge, deat ation and/or in	h occurred	d at the time n, in my or	ne, date an pinion, deal	d place, a th occurre	and due to the ed at the time,	cause(s) date and	and manner place, and d	as stated. ue to the cause(s)	
To t Comp	Z	29b. Signature and title of certifier	late 1	· Pet	-m1).		c. License		,0-	>		_	nth, Dey, Year)	(
10		30. Name and address of person who	K. 4	MEL	-MD 1	Print)	Sin	SER	LCY.	AVE,	EL	KTO	Y MD21	921
S Regis	tate trar	31. Date filed (Month, Day, Year) MAR 0 2	2004	Registrar's Sign	ature	1								

ORIGINAL

SPENCE		1- For Amend Item#1 State Registrar Unpend Item#23a,2	ate of Maryland / Depa	artment of Health and M	ental Hygien		0651
Physic /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Tony Kirk Spence			February (		3. Time of Death  08:32
Exami Funeral Director	ner	4a. Facility Name (If not institution, give street 1458 Barret Road  5. Social Security Number Unk 6. Sex 1 🖾 M 2	7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death  Catonsville  If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day, July 10,	Baltimor 9. Birthplant 1966 Mary	ce ace (State or Foreigr 71 and
D D		Usual Residence of Decedent  10a. State 10b. County  MD Baltimore	10c. City, Town or Lo	cation onsville			d. Inside City Limits
h with the 23a or 28s	al Director	10e. Street and Number 1458 Barret Road		10f. Zip Code 21228	10g. C	Citizen of What Count USA	ry?
hours after death with the Maryland tural', or thems 23a or 28a-f show al Enginical privat be notified at	by Funeral	12 Never Married 2 Married 1	TYes 21 No	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2ሺ No Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: V	n Indian, tc. vhite
within 72 ane. than "nai	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) (Give life. L	dent's Usual Occupation kind of work done during most of workil DO NOT use retired) ee hauler	ng	Kind of Business/Indi	,
	To Be Co	17. Father's Name (First, Middle, Last) Frank F. Spence			(First, Middle, Maide ie Behne	on Sumame)	
1 and 2 Health a em 27 ls		19a. Informant's Name/Relationship (Type, P. Bridgette Willis/sis  20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remov	ster 3145	Strickland Street sition (Name of matory or other place)	Baltimor		29
permit. Pages Department of Important: If it ony injury or o		4 □ Donation 5 🖔 Other (Specify) i  21. Signature of Funeral S ruice Licensee  N of	n state L. Director St	Name and Address of Facility Eate Anatomy Board	655 W. Ba	ltimore Si	treet
-nysician /Medical Examiner		resulting in death)	is that caused the death. Do not enterse on each line.  Combined Narcotic Into Due to (or as a consequence of):  Due to (or as a consequence of):		respiratory arrest,		Approximate Interval Between Onset and Death
eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence of):				
y the	hysician/Med	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of deliven Month	/ Day Year
s been signed be should be detail	by P	Part II. Other significant conditions contribut	ing to death but not resulting in the ur	nderlying cause given in Part I.		use contribute to the	cause of death?
The law ate has b page 2 sl	Completed				24a. Was an autopsy performed?	death?	sy findings available pletion of cause of
ding Phys h. After this tuneral di	ation: To Be	1 □Natural 5 □ Pending 2 □ Accident investigation	al: 1   Inpatient 2   ER/Outpatieni a. Date of Injury (Month Day Year)  found 2/6/04   Unknown	28c. Injury at 2 Work?	(Check only one) ne 5 □ Residence 8d. Describe how inju	ther (Specify)	SCENE
Hospitel or Attan.     24 hours after deatl     Funaral Diractor: letely filled in by the	Certification:	re	e. Place of Injury - At home, farm, stre building, etc. <i>(Specify)</i> sidence	1	City or Town, Stat 458 Barret R	d, Catonsvil	le, MD
To the Hosp within 24 hor To the Funa completely fi	Medical	(Check only 2/2 Medical Exeminer: C	: To the best of my knowledge, death on the basis of examination and/or inv nd manner stated.	occurred at the time, date and place, a restigation, in my opinion, death occurred 29c. License number	d at the time, date an	s) and manner as stated and place, and due to to the action at the signed (Month, Date 1)	he cause(s)
M. W.		Mayore Jone y	fell un	O.C.M.E.		ruary 7, 2	
St	ate	31. Date filed (Month, Day, Year)	REU 111	Penn Street, Balt	imore, Ma	ryland 212	01
Regist	rar	MAR 0 2 2004	Statemen At La	north .			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 24, 2004 Paul Alexander Steppe, Jr. 10:30 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Bayview Medical Center If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) May 19, 19 5. Social Security Number Birthplace (State or Foreign Country) Months Days 1 □ M 2 □ F 71 1932 213-28-9054 N. Carolina Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Baltimore Maruland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Chapeltowne Circle 21236 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 Ayes 2 Thomas If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White. 3 ☐ Widowed 4 X Divorced Year or Dates Conflict 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) International Sales Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Alexander Steppe. Sr. Meda M. Brendall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meda M. Brendall (mother) 13 Chapeltowne Circle, Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem'l Gar. 2/28/04 Timonium, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licenses 9705 Belair Rd., Baltimore, MD 21236 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ok, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Arrest ardiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Artery (OVOVOVY Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Melagladie 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

be filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mentel Hygiene. Important: If item 27 is marked other then "netural", or items 23a or 28a-f show any injury or other traumatic event, the Mactical Examinat mast be notified at

/Medical

Director

Funeral

5

Completed

Be

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Physician/Medical Examiner

The law requires that the death certificate be executed anding physician and use as the burial-transit page 2 should be detached has certificate funeral director. Director: After this

Division of Vital Records, P.O. Box 68760,

Completed by Be Certification: To

completely filled in by To the Hospital or within 24 hours e

State Registrar

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier B. Heg

5 Pending

investigation

6 Could not be determined

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 LANatural

2 Accident

3 Suicide

4 Homicide

(Check only

M

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

60539

28c. Injury at Work?

29c. License number

1 TYes 2 TNo

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) 2-25-04

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. Eulow St, St. 308, Baltimore NJ 21204

31. Date filed Month, Day, Year) 32. Registrar's Signature MAR 0 2 2004

Lieu & Sporter .

		1	For State Registrer	State of Maryland /		artment of Hortificate of L		Mental Hyg	giene Reg. No. 4	2004	06512
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic	al	Helen Louise Serr					FEBRU		24, 200	4:19PM
)	Examin	- 24	la. Facility Name (If not institution, give s Saint Joseph	street and number) Medical Cent	cer	4b. City, Town, or	Tow	son		Bal	timore
	Funeral	4	5. Social Security Number 6. Sex 15-40-0510	7. Age (in yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h y, Year) 5, 19	9. Birth Cou 42 Ma	place (State or Foreign ntry) aryland
è	Director		Usual Residence of Decedent					-			40d Inside City Limite
	ylano how	.	10a. State 10b. County  Md. Harford	10c. City, To	own or Lo	ocation White Hal	1				10d. Inside City Limits 1 ☐ Yes 2 🗷 No
	sa-f s	Director	114.	<u> </u>					10a Citizer	n of What Cou	
	with th	Dire	10e. Street and Number 4764 Amoss Road			10f. Zip Code	161		-	ted Sta	•
	s 23g	erai		12. Was Decedent Ever in U.S.	13.	Was Decedent of Hi	spanic Origin? (9	Specify Yes or No	. 14.	Race - Ameri	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show amy righty or other treumatic event, the Medical Exertifier must be notified at Once.	by Funerai	1 ☐ Never Married 2K Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Tyes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puer Specify:	to Hican, etc.)	Sp	Black, White pecify: wh:	
5	2 hou	ted	15. Decedent's Edu (Specify only highest grad		6a. Dece	dent's Usual Occupa	ation during most of wo	rking	16b. Kind	of Business/Ir	ndustry
7	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lite.	DO NOT use retired	)			own hoi	m o
V	ygien ygien her th		9 years		noi	memaker	18. Mother's Na	me (First, Middle,			ile
2	ntal H ed otl	m	<ol> <li>Father's Name (First, Middle, Last)</li> <li>John Ambrose Hami</li> </ol>	ilton				Frita W			
Ž	hould Me	2	19a. Informant's Name/Relationship (T)		19b. Mail	ing Address (Street a	and Number or R	ural Route Numbe	er, City or T	own, State, Zi	ip Code)
Z	od 2 suith an 27 is r treu		Frank Serruto, Si		476	4 Amoss Ro	oad, Whi	te Hall,	Md.	21161	
e,	s 1 ar f Hea ltern othe		20a. Method of Disposition	20b. Placi	e of Disp	osition (Name of ematory or other place	θ)	Date	20c. Loca	tion - City or T	own, State
Ē	Page nent o int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  1 ☐ Donation 5 ☐ Other (Specify)	entombment Be	l Ai	r Mem. Gdi	ns. 2/2	8/04	Be1	Air, M	d.
saltimore	mit. partin porta y inju		21. Signature of Funeral Service Licens	99.	2	2. Name and Address Schimune	s of Facility K Funera	1 Home o	f Bel	Air,	Inc.
<u>n</u>	89 5 8	18	(Claritett)	SOUR !	- 31	610 W. M	acPhail	Road Be	1 Air		21014 — — Approximate
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ine cause on each line.				ic or respiratory a	11051,		Interval Between Onset and Death
}	Physician		Immediate Cause (Final disease or condition resulting in death)	a Multi Syst		Organ Fa	ailure				
	/Medical Examiner			Due to (or as a consequent	nce of):						
gle.	W. 36	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequen	nce of):						
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	. Ferforated	d Di	venticu	litis				
o,	an an	Exa	resulting in death) Last	Due to (or as a consequen	nce of):						
3/60	cate be executed physician and the burial-transit	dicai		d							
Õ	ertifica ding p	Mec	IF FEMALE:	23c. If yes, outcome of pregnance	v				23	d. Date of deli	verv
O. Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	eath 3	□Ectopic pregnancy □ Other (specify)				Month	Day Year
٦.	The law requires that the ate has been signed by th page 2 should be detache	Ph	Part II. Dther significent conditions co	ontributing to death but not resulti	ng in the	underlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
Sp.	uires sign ld be	d by						10	Yes 21	No 3□Pr	obably 4 Unknown
Ö	w req	Completed						24a. Was		24b. Were au	topsy findings available completion of cause of
Re	The tav te has age 2	шо						perfe	ormed? 2 X No	death? 1 ☐ Yes	2X1 No
ta		a a	25. Was case referred to medical				26. Place of D	eath (Check on	one		
>	Physic this ce al direc	To B	examiner?		R/Outpati		4   Nursing	Home 5 ☐ Res			cify)
0	ng PI after th		27. Manner of ©eath 1 X Natural 5 □ Pending	(Month, Day Year)	8b. Time Injury	Wor	yat k? Yes 2 ⊡No	28d. Describe	now injury	occurred	
sio	tendi leath. tor: A the fu	cati	Accident investigation  3 Suicide 6 Could not be		e farm		165 2 100	28f. Location	Street and	Number or Ru	ıral Route Number,
Division of Vital Records,	or At after of Direct in by	Certification;	4 Homicide determined	building, etc. (Specify)	o, raini, .	grost, ractory, orno		City or To	wn, State)		
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifical completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Ph. (Check only one)	ysicien: To the best of my knowled inter: On the basis of examination and manner stated.	edge, de n and/or	ath occurred at the til investigation, in my o	me, date and pla opinion, death oc	ce, and due to the curred at the time	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
	o the	Med	29b. Signature and title of certifier	1 0 1	7	29c. Licens	se number		29d. Date	signed (Mont	h, Day, Year)
	₩ S ₩ Ö		> (aut	h From M.	V.	D	24034		2	124/	74
	0		30. Name and address of person who	completed cause of death (Item 2	23a) (Typ	e, Print)				1	
	49.7%		TIMOTHY LOW.	M.D., 7601 0		RDRIVE	TOWSON.	MARYLA	ND 2	1204	
		ate	31. Date filed (Month, Day, Year)	2 2004 Silvere	re M	breek a					
	Regist	ırar	U MAIN	1 LUU4 PROGRE	15	Agente					

DHMH 17 Rev 1/2001

ORIGINAL

	_1	State Registrar	ate of Maryland / [	Certificate o		F	1eg. No. 200	
Physicia	~ .	Decedent's Name (First, Middle, Last)	mngon TTT			2. Date of Dea Month	Day Year	3. Time of Death
/Medic	al 🖅	Rayford A. San  a. Facility Name (If not institution, give street	mpson III	4h City Town	, or Location of Dea		ry 28, 2004 4c. County of Dea	
Examin	er	Route 140 west of M			neytown		Carro	
Funeral		Social Security Number 6. Sex 112–52–4597		rthday) If Under 1 Yea	ar If Under 24 Hr		h 9. Bir	thplace (State or Fore
Director		l12-52-4597 <sup>™</sup>	<sup>2□ F</sup> 45	Yrs. Months Day	s Hours Mir	Dec. 4,	1958 Was	hington,D(
2		Isual Residence of Decedent  0a. State 10b. County	10- Ob. T					10d. Inside City Lim
ahov	٦		10c. City, Tow					
Ba-f	ecto	MD Baltimore Oe. Street and Number	Owi	ngs Mills			10g. Citizen of What C	1 Tes 2
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The them 27 is marked other then "netural", or liems 23a or 28a-f ahow lither 27 is marked other the Medical Exant is a must be notified at other treumatic event, the Medical Exant is a must be notified at	D	14 Rozina Court			, 21117		USA	ountry r
ns 23	Funeral Director	1 Marital Status 12. V	/as Decedent Ever in U.S.	13. Was Decedent of		Specify Yes or No-		erican Indian,
r Iter	필	1 Never Married 2 XMarried 1	med Forces?  ☐Yes 2X No			rto Rican, etc.)		te, etc.
Eran	þ		Yes, Give lear or Dates:	1 ☐ Yes 2X N	lo Specify:		Specity: B1	ack
netu	Completed	15. Decedent's Educatio (Specify only highest grade con		Decedent's Usual Occ	cupation ne during most of w	orking	16b. Kind of Business	/Industry
. ue.	npi du	Elementary/Secondary (0-12)	ollege (1-4or 5+)	(Give kind of work do life. DO NOT use ret lechanical			Federal Go	wernment
lygier har th	S -		5+ 14	lechanicai		ame (First, Middle,		veriment
od ott	ã	7. Father's Name (First, Middle, Last)	C ~				,	
d Mer nark	ဥ	Rayford A. Sampson,  19a. Informant's Name/Relationship (Type, F		o. Mailing Address (Stre		ne D. Wil		7in Code l
traur		Vicki Anne Sampson	·					
Heall Heall		Oa. Method of Disposition	20b. Place o	Rozina Con Of Disposition (Name of		Date	MD 21117 20c. Location - City or	
Definit. Peges Department of H Important: If Ite any injury or ot		1 XBurial 2 Cremation 3 Remo	val from State	ry, crematory or other p	1	6/0/		
artme ortan injur	-	21. Signature of Funeral Service Licensee	Evelgi	een Mem. Ga			Finksburg,	
Depa Impo Impo Once		Mark 11 ) eskil	wice		uneral Ho	- 100 Control	Reisterst erstown, M	
CHES		23a. Part1. En of the disease, or complication shock, or heart failure. List only one ca	ns that would the death. Do			NC 15 t		Approximate Interval Between
Medical Examiner  physicien and the bruial-transit	dicai Examiner	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	Due to (or as a consequence  Due to (or as a consequence  Due to (or as a consequence	of):				
that the death certilicaled by the attending photograph detached for use as the	by Physician/Med	in the past 12 months?	yes, outcome of pregnancy  Live birth 2 Fetal death  Pregnant at time of death  Unknown	n 3⊟Ectopic pregnal 5⊟ Other (specify)			23d. Date of de Month	livery Day Year
gned be del	ed by	Part II. Other significant conditions contribu	ting to death but not resulting i	in the underlying cause	given in Part I.		bacco use contribute t res 2 ⊠No 3 □ P	o the cause of death robably 4 DUnkn
en sig	Completed						an 24b. Were a prior to death? 2 \( \text{No} \) No 1 \( \text{Yes} \)	utopsy findings avail completion of cause 2 No
n: The law requires ficate has been sign r, page 2 should be			tol		Other	eath (Check only or		
sician: The law requires certificate has been sig irector, page 2 should b	Be	25. Was case referred to medical examiner?  177 Yes 2 7 No Hospi	di. 4 Dippetient a DEDIO	utpatient 3 DOA	4 L Nursing		lence 6 XOther (Speciow injury occurred	
I rnystcian: The taw requires st this certificate has been signed director, page 2 should b	To Be	examiner? 1X Yes 2 □ No Hospi	1 inpatient 2 EH/O		ijury at	280. Describe n		JEW JE CIE
oding Prhysician: The law fequires tith. :: After this certificate has been sig e funeral director, page 2 should b	To Be	examiner?  1X Yes 2 No  Pospi  Manner of Death  Natural 5 Pending	Ba. Date of Injury (Month, Day Year)	Time of 28c. In	liury at Vork? Yes 2 100	Driver Oca	DR, IMPDUTUR	14 Much, FIX
el or Attending Physician: The law requires s after death. I Director: After this certificate has been sig ad in by the funeral director, page 2 should b	To Be	examiner?  1X Yes 2 No  Hospi  27. Manner of Death  1 Natural 5 Pending investigation  2 Accident No Could get by	a. Date of Injury (Month, Day Year)  Je Place of Injury - At home, fabuilding, etc. (Specify)	Time of lnjury 28c. Irr V 1 28c. Irr V 2 28c. Irr V 2 28c. Irr V 2 28c. Irr V 3 28c. Irr V 4 28c. Irr V 5 28c	☐ Yes 2 No	28f. Location (S City or Tow	Street and Number or R n, State)	NH Much, Fix ural Route Number,
ne Hospitel or Attending Physician: The law require At bours after death.  Ins Funerel Director: After this certificate has been significately filled in by the funeral director, page 2 should b	Certification; To Be	examiner?  1\times Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Ba. Date of Injury (Month, Day Year)  LU-04  1 EPOOL	Time of Injury 28c. In Injury 1 28c. In Injury 2 28c.	Yes 2 No	28f. Location (S City or Tow EBRT14	Street and Number or R m, State) O W & E MAY () cause(s) and manner a	THE THUCK, FIX UTAIL ROUTE ROU
to the Hospitel or Attending Prysician: The law requires within 24 hours after death.  To the Funerel Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	To Be	examiner?  1\times Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	a. Date of Injury (Month, Day Year)  Be. Place of Injury - At home, fabuilding, etc. (Specify)  To the best of my knowledge On the basis of examination ar	Time of Injury 28c. In V 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Yes 2 No	28f. Location (S City or Tow ES RT 14 ce, and due to the courred at the time.	Street and Number or R m, State) O W & E MAY () cause(s) and manner a	NH THLLE, FIX.  Ural Route Number,  EMY FLD CASU  s stated.  e to the cause(s)
tending Physician: The lav Jeath. tor: After this certificate has the funeral director, page 2	edical Certification; To Be	examiner?  1 Yes 2 No  Hospi  27. Manner of Death 1 Natural 2 Naccident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	Be. Place of Injury (Month, Day Year)  Be. Place of Injury - At home, fabuilding, etc. (Specify)  To the best of my knowledge On the basis of examination and manner stated.	Time of Injury 28c. In Injury 11 28c. In Injury 12 28c. I	Yes 2 No	28f. Location (S City or Tow ES RT 14 ce, and due to the courred at the time.	Street and Number or R. m., State)  Ower MAYN cause(s) and manner addte and place, and durantees	THE TRUCK, FIX.  Ural Route Number,  ENLY PLD CASE  s stated.  to the cause(s)  th, Day, Year)
To the Hospitel or Attending Physician: The law require within 24 hours after death.  To the Funerel Director: After this certificate has been sig completely filled in by the funeral director, page 2 should b	edical Certification; To Be	examiner?  1 Yes 2 No  Hospi  27. Manner of Death 1 Natural 2 Naccident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	Be. Place of Injury (Month, Day Year)  Be. Place of Injury - At home, fabuilding, etc. (Specify)  To the best of my knowledge On the basis of examination and manner stated.	Time of Injury 28c. Injury 1 arm, street, factory, office e, death occurred at the advor investigation, in m 29c. Lice (Type, Print)	e time, date and pla y opinion, death occurs number	28f. Location (S City or Tow Etc. RT 14 ce, and due to the courred at the time, of	Street and Number or R. m., State)  O W & MAY ()  cause(s) and manner a date and place, and during the signed (Monitorial Control Cont	THE MULL FIX ULTER POLICE POLI

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		•	1 - State Amend Item 5 pe	State of Maryla er FH,G829,03/16	nd / Depa /04dhb Ce	artmer rtifica:	nt of He te of C	ealth a Death	and M	lental Hy	giene , Reg. No. <sup>6</sup>	2004	06514
			Decedent's Name (First, Middle, Last							2. Date of De	ath		3. Time of Death
	Physicia		TIMOTE	ty W 51	+ AR	PE				Month Fea	Day 24	2007	1459 M
	/Medic Examin		4a. Facility Name (If not institution, give				, Town, or	Location of	of Death		4c. C	ounty of Deat	th
			Northwest Hospita	1		Ran	dalls	stown	ì		В	altimo	
	Funeral		5 Social Security Number 6. Se 242-96-5399	2	. last birthday)	If Unde	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	h y, Year)	9. Birt	thplace (State or Foreign ountry)
н	Director		217.96-5399	M 2□F 3 8	Yrs.					01-16-			rth Carolina
	pu k	}	Usual Residence of Decedent  10a, State 10b, County	10c. C	ity. Town or Lo	ocation						-	10d. Inside City Limits
	aryla •ho	7											1 ☐ Yes 2 No
	Ne N	Director	Md Baltime	ore R	anda11		p Code				10a Citiza	en of What Co	ountry?
	with	급											,.
	eath	Funeral	9209 Liberty Road	12. Was Decedent Ever in	U.S. 13.		21133	spanic Ori	igin? (Sp	ecify Yes or No	U.S	A. Race - Ame	erican Indian,
	iter d	5	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		If Yes, spe	cify Cubar	n, Mexicar	n, Puerto	Rican, etc.)		Black, Whit	
36	ors af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 No	Specify:			5	Specify: W	nite
21215-0036	2 hou	Completed	15. Decedent's Edu		16a. Dece	dent's Usu	ual Occupa ork done di	tion	t of work	ina	16b. Kind	d of Business	Industry
215	hin 7	Be	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired)	uning mos	i or work	uig			
2	giene giene	P P		3	S	elf E	mp1oy	zed			Furn:	iture I	)ealer
	al Hy loth	Be (	17. Father's Name (First, Middle, Last)					18. Mothe	er's Nam	e (First, Middle,	Maiden S	iumame)	
Ja	Ment Ment wrked	ဥ	Conrad Thomas Sha	rpe				Bet	ty R	ominger			
an	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 ie marked other then "natural", or iteme 23a or 28a-f show other traumatic event, its Medical Examinar must be instiffed at		19a. Informant's Name/Relationship (T)	ype, Print)						al Route Numbe			
Σ	of Health au item 27 le		Janet Hayes					111 D					olina 27539
ore.	of He		20a. Method of Disposition  1 Burial 2 Cremation 3 1		Place of Dispo cemetery, cre	osition (Na matory or	me of other place	e)	1	Date	20c. Loc	ation - City or	Town, State
Ĕ	Pag nent ant: I		4 □Donation 5 □ Other (Specify,	Ва1						-2004			
Baltimore, Maryland	permit. Pages 1 and Department of Healt Important: If Item 2 eny injury or other once.		21. Signature of Juneral Servica Licens	600	2	2. Name a	nd Address	s of Facili	<sup>ty</sup> Lor	ing Bye	rs Fu	neral	Directors In
m	8° = 5° 8		Choroland	2	8	728 L	ibert	y Ro	ad	Randa11	stow	ı, Mary	land 21133
8760,	Medical Examiner  bhysician and sthe burial-transit	cal Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.	equence of):								
.O. Box 6	law requires that the death certificate be exboded as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	⊒Ectopic p ⊒ Other (s					23	3d. Date of del Month	ivery Day Year
۵.	res that igned b be deta	by PI	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	underlying	cause give	n in Part I	l,	23e. Did t	obacco us	e contribute to	the cause of death?
ĕ	w require been sig should b	pa								10	res 2/Z	No 3□Pr	robably 4 Unknown
Records,	aw requ is been 2 shouk	Completed								24a. Was		24b. Were au	utopsy findings available completion of cause of
Ä	The lavate has	mo								perfo	rmed?	death? 1 ☐ Yes	
Vital	ician: Th certificate rector, pag	a	25. Was case referred to medical					26. Place	e of Deat	h (Check only o			
>	d in	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 D	OA Othe			ome 5 Resi		☐Other (Spe	cify)
o	g Ph er th		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of	28c. Injury Work	at ?		28d. Describe	now injury	occurred	
Division	uttending F death. ctor: After y the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Buy 7 sur)	IIIquiy	М		res 2 🗌	No				
Vis	r Attender death rector:	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, facto	ry, office			28f. Location (a City or Tox		Number or Ru	ural Route Number,
ā	s afte el Dir	Certification:		Suitaing, etc. (Open						J., G	, 2.3.0/		
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical (		vsician: To the best of my k iner: On the basis of examinand manner stated.									
	To the within 2 To the complet	ž	29b. Signature and title of certifier			29	c. License	number			29d. Date	signed (Mont	h, Day, Year)
			C-011-				D	290	ې چر ن	-	150 1	Q 7. L	2004
	10		30. Name and address of person who d	ompleted cause of death (It	em 23a) (Type	, Print)			-				7
	10		Allon J. Chi	cus ma	5	310	0	10 0	200	C+ R	000		21133
	Sta Registi	_	31. Date filed (Month, Day, Year)  MAD 0 2 205	32 Registrar's Sig		- 60 0							

	1 - For State Registrar	State of Mary		artment of F			giene Reg. No. 2 (	004	06515
Physician						2. Date of De. Month Feb.	Day	Year 2004	3. Time of Death 7:40 Å M
/Medical Examiner	A. E. Nie Name //f not institution of	rive street and number)		4b. City, Town, o	r Location of Death	h	4c. County Balti	of Deeth more	
Funeral Director			yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da June 7	h y, Year) 1922	9. Birthpl Count PA	ace (State or Foreign try)
aryland show	Usual Residence of Decedent  10a. State  10b. County	ĺ	Cooks					10	0d. Inside City Limits 1 ☐ Yes 2 📉 No
buter death with the Maryla vittems 23s or 28s-4 shours must be notified at	MD Baltim  10e. Street and Number	ore	Cocke	10f. Zip Code			10g. Citizen of		
s 23a c	10110 Daventr	y Drive	rin U.S. 13		030 tispanic Origin? (S	pecify Yes or No	- 14. Rad	A America	an Indian,
d 21215-0036 filled within 72 hours after death with the Maryland Hygiene then naturell, or items 23s or 28s-f show ont, the Medical Examinational Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	o Rican, etc.)	Specif	ck, White, e	white
21215-0036 bd within 72 hours alt gjene. er than "naturel", or than Madical Exam. the Madical Exam.	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	pation during most of word d)	rking	16b. Kind of B	usiness/Ind	ustry
d 212 d 212 filed with Hygiene. sut, the	Elementary/Secondary (0-12)	College (1-4or 5+) 3 1/2	Acc	ountant/S					ications
E REPA	17. Father's Name (First, Middle, La William Shetz	st)				ne (First, Middle, et Devli		ne)	
Maryla d 2 should th and Mer treumatic	19a. Informant's Name/Relationship  Margaret Shet			ng Address (Street  Daventr					
0, 200 6	20a. Method of Disposition 1 □ Susial 2 □ Cremation 3	- Community - State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place	ce) 3/4/	Date 04	20c. Location	- City or To	wn, State
Baltimore, permit. Pages 1 at Department of Hea Important: If item eny injury or othe	4 ☐ Donation 5 ☐ Other (896) 21. Signature of Funeral 3 price (1)	3/19)	Dulaney 22	Name and Addre	es of Facility				
Bal permi Depar Impo	Bryan W. C	lary	death Do not en	Lemmon I	donia Rd	Timor	Dulanev nium, M	y vai D 210	ley, Inc. 193 Approximate
Physician	shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each line.					,,		Interval Between Onset and Death
Medical Examiner, le be executed e burial-transit	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co		and d	ement	rà			years
BB Bath Bath for the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у			ate of delive	ory Day Year
S, S, Ses III	Part II. Other significant condition	s contributing to death but n	oot resulting in the u	inderlying cause giv	ven in Part I.	23e. Did t			ne cause of death? ably 4 Unknown
Vital Record Vital Record sician: The law requires contilicate has been s irrector, page 2 should	Completed					24a. Was auto perfo 1 ☐ Yes	psy ormed?	Were autor prior to con death? 1 \( \sum \text{Yes} \)	psy findings available npletion of cause of 2 No
of Vita Of Vita Physician: this certific	25. Was case referred to medical examiner?	Hospital:	•	Ot	han.	ath (Check only of			Hospico
On of sing Physical distributions of the sing Physical distributions of the sing Physical distribution of th	1 Yes No 27. Manner of Death 1 Natural 5 Pending		2 ER/Outpatie 28b. Time of lnjury	of 28c. Inju	ry at rk?	-	how injury occur		Mospice
or Attence the death oilector: in by the	27. Manner of Death  1	t be 29a Place of Injury	- At home, farm, st Specify)		]Yes 2□No	28f. Location ( City or To		ber or Rura	l Route Number,
To the Hospital within 24 hours a To the Funeral Completely filled	29a. Certifier 1 Certifying (Check only 2 Medical E	Physicien: To the best of m xaminer: On the basis of ex and manner stated	amination and/or in	vestigation, in my	opinion, death occi	urred at the time,	date and place,	and due to	the cause(s)
To the comple	29b. Signature and title of certifier	1 1		29c. Licen	se number	3	29d. Date signs	ed (Month, I	Day, Year)
• X	29b. Signature and title of certifier  30. Name and address of person w  W. A. L. [ ]  31. Date filed (Month, Day, Year)  MAR 0.2	ho completed cause of deat	th (Item 23a) (Type	Print)	200	20	1-elone	aya	7,2007
()	W.A. Riley	G-BMC 670	N.Cl	ale S	it. Bal	to md	2120	~	
State Registra	MAR 0 2	2004 Segistrars	J. J. A	best					

			1 - For State Registrar	State of Man		artment of He rtificate of D		ental Hygier Reg. I	200	0651
Ŧ	Physici	an	1. Decedent's Name (First, Middle, La	st)	5			2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Nauch	٦.	Shide			- / -	29, 2004	7:17 P M
	Examin	er	4a. Fecility Name (If not institution, given the Carroll H	e street and number) Ospital Cei	م جده	4b. City, Town, or I	Location of Death		4c. County of Death	//
	Funeval	7 - 17	5. Social Security Number 6.3		n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	B. Date of Birth		olece (State or Foreign
ŀ	Funeral Director		276 44 0667	□M 2XSF 83	Yrs.	Months Days	Hours Min.	(Month, Day, Yea Apr 28,	1920 Net	v York
	pu ,		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Le	acation				Od. Inside City Limits
	shon	ō								1 ☐ Yes 2 No
	28e-1	Director	MD Carro	L.L.	Sykesvi	10f. Zip Code	<del></del>	10g. (	Citizen of What Cour	ntry?
	3a or	iDi	710 Obrecht Road			21784		Ui	nited Stat	tes
	death	Funerai	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spec	ify Yes or No-	14. Race - Americ Black, White,	can Indian,
36	be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "natural", or items 23a or 28e-f show event, I'le Mexical Exertitus missible mullish at	y Fu	1 Never Married 2 Marned	1 XYes 2 No		1 ☐ Yes 2 ☑ No	Specify:	10411, 010.7	Specify:	
21215-0036	hours tural',	d by	3 √Widowed 4 Divorced	Year or Dates: WW		dent's Usual Occupa		164	Wh:	ite
15	in 72 in n	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	kind of work done du DO NOT use retired)	iring most of working		, Kind of Business/In	uusiiy
212	d with giene.	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	Hor	memaker			Own Home	
pu	2 should be filed within and Mental Hygiene. ie marked other than aumatic event, the Mental than a marken and the Mental than a marken and the Mental than the	BeC	17. Father's Name (First, Middle, Last	)			18. Mother's Name (		en Sumame)	
yla	should be f and Mental H marked of umatic ever	To	Robert Julia				Arlene Pa			
Baltimore, Maryland	ges 1 and 2 should t of Health and Men If Item 27 ie marke or other traumatic		19a. Informant's Name/Relationship (Stephanie Scott/)	* -		ng Address <i>(Street ar</i> 2 Davis Av				Code)
e,	permit. Pages 1 and i Department of Health Importent: If Item 27 any injury or other tr once.		20a. Method of Disposition		20b. Place of Dispo	osition (Name of	Da		Location - City or To	own, Stete
JOH.	Pages nent of I int: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Metro Cre	matory or other place cmators	3-1-2		tonsville	
altir	permit. Pa Departmen Importent: Iny injury	pi	21. Signature of Funeral Service Lice							lly FH Inc.
ä	Depa Impo any ir		Den Colla	5 Wille		112 Old Co				
P			23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do not en	ter the mode of dying	, such as cardiac or	respiratory arrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	a		Sepsis				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):					- /
Ŀ		10	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of):					
	uted d ansit	Examiner	Cause (Disease or injury							
o Î	exect an and rial-tra		that initiated events resulting in death) Last	C. Due to (or as a co	onsequence of):					
8760	icate be executed physicien and s the burial-transit	dicai	•	d						
9	death certificate be executed e attending physicien and id for use as the burial-transit	Med	IF FEMALE:							
Вох	eath certif attending for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy			23d. Date of delive Month	Day Year
P.O.	that the de ed by the a detached t	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at tim 9☐Unknown	e ot death 5L	Other (specify)	····			
	The law requires that the ste has been signed by th page 2 should be detache	by Ph	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	inderlying cause giver	n in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
rds	tw requires that s been signed I s should be det							1 🗋 Yes	2 ØNo 3 ☐ Prob	ably 4 🗀 Unknown
of Vital Records,	e law re has bee	Completed						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
Ä		Com						performed:	death?	
/ita	Physician: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?				26. Place of Death (	Check only one)		
of	Physi this c	2	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie		4   Nursing Home		6 ☐Other (Specif	v)
	ding I h. Alter funer	tion	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Ye	28b. Time o Injury	Work	es 2 No	d. Describe how in	jury occurred	
Division	Attending r death. ector: Alter by the fune	fica	3 Suicide 6 Could not b	e 28e. Place of Injury	- At home, farm, str				and Number or Rura	il Route Number,
á	al or A s after at Dire	Certification:	4 Homicide	building, etc. (S	Specify)	•		City or Town, Sta	ate)	
	To the Hospital or Attending Physician: within 24 hours atter death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of miner: On the basis of example and manner stated	amination and/or in	h occurred at the time vestigation, in my opi	o, date and place, an nion, death occurred	d due to the cause at the time, date a	(s) and manner as si and place, and due to	ated. the cause(s)
<b>\</b>	To the within To the Comp	Me	29b. Signature and title of certifier	pm ( Joe	lmo	29c. License	number 0059943		Date signed (Month,	
	iti		30. Name and address of person who	completed cause of death	n (Item 23a) (Type.	Print)			mary 2	
			John C. Abel,	M.D. 295		Ave. 5	vite 307	west	minster,	MD 21157
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's		,				
DH	Registr	_	MAR 0 2 200	Deprison	- 3	hours	>	-		

DHMH 17 Rev 1/2001

ORIGINAL

		•	1 - For State Registrar		epartment of Health and N Certificate of Death		ene 2004	06518
			1. Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
	Physicia		Dorothy B. T	aylor		02- 3	29-2004	10:15 P. M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Exami		Wesley Home		Baltimore City			
Ŧ	Funeral		5. Social Security Number 6. Sex		nday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birth	place (State or Foreign
	Director		216-14-0369	IM 2026F 84 Y	rs. Months Days Hours Min.	April 18	,1919	MD
	ס		Usual Residence of Decedent					And the late of the balls
	ylan how		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	Mar Mar	ţō	MD Baltimo	re Tows	on			1 ☐ Yes 2 🛣No
	1 the	Director	10e. Street and Number		10f. Zip Code	16	g. Citizen of What Cou	intry?
	death with the Maryland ms 23a or 28a-f show		56 Acorn Circle #	201	21204		USA	
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
	or ite		1 Never Married 2K Married	1 Tes 2 No	1 ☐ Yes 2 ☒ No Specify:	Tilouri, oto.,	Specify:	, 010.
2-003p	En.	þ	3 Widowed 4 Divorced	Year or Dates:	1 163 2 Q NO Spacity.		Wh	ite
2	within 72 hours after ene. than "natural", or ite he Wedfeal Emar	Completed	15. Decedent's Educ (Specify only highest grade	cation 16a. (	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of Business/li	ndustry
N	thin thin	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)			
7	gien er th	ő		4	Teacher		Education	
Ē	be filed within 72 hours after death with the Marylan Ital Hyglene. Id other than "natural", or items 23a or 28a-f show ovent, the Medical Expression in the recipited at	Be (	17. Father's Name (First, Middle, Last)		18. Mother's Nam		faiden Sumame)	
/ian	~ ⊂ ~	၉	Edward L. Beaucha			ne Tull		
Man	2 sho and is mu	0 89	19a. Informant's Name/Relationship (Ty		Mailing Address (Street and Number or Run			p Code)
	as 1 and 2 shouk of Health and Me fitem 27 is mark r othar traumatic		Judith Hughes		Albright Ave., Glyn			
Baitimore,	r ser H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	20b. Place of cemeter)	Disposition (Name of v, crematory or other place)	Date	20c. Location - City or T	own, State
Ĕ	permit. Pages Department of I Important; if its any injury or o		`4 □ Donation 5 □ Other (Specify)	Carrol	1 Cremation $3/2/0$	)4	Hampstead,	MD
= =	permit. Departing Imports any injustical.		21. Signature Funeral Service License	<del>•</del>	22. Name and Address of Facility	11824	Reistersto	wn Road
n	88 = 8		1 / will leak	:CWIZ	Eline Funeral Home	KETSCE	rstown, MD	21136
			23a. Pert1, Enfer the disease, or compli	cations that caused the death. Do not be cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ARDIAC ARRHY	ZIMIA		Onset and Death
7	/Medical		resulting in death)	Due to (or as a consequence of	it):	711111		710070
	Examiner		and the second second	ACUTE MY	OCARDIAL INFA	RCTION	/	WEEKS
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	of):			
	dansit	Examiner	Cause (Disease or injury that initiated events	Due to (or as a consequence of	ARTERY DISCAS	E		YEARS
'n	sician and burial-transit		resulting in death) Last	Due to (or as a consequence of	of):			•
8760,	ate be executed hysician and the burial-transit	dical		J				
Õ	ifficate g phys as the	edi					30	
Вох	Jeath certifica attending ph d for use as t	5	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of deliv	,
m.	deatle atte	icia	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant at time of death	5 Other (specify)		Month	Day Year
O.	that the de led by the a detached f	hys	9 ☐ Unknown	9□ Unknown				
ر. ت	res tha igned l be det	y P	Part II. Dther significant conditions cor	tributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ğ	quire n sig uld b	De p	CONGESTIVE C	CARDIO MYOPATH	17	1 □ Ye	s 2 □ No 3 □ Pro	bably 4 Unknown
ဝ္ပ	w require been si should b	lete				24a. Was a		opsy findings available
Re	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Me				autops perform	ned? death?	ompletion of cause of 2 ☐ No
ā	ification, per		25. Was case referred to medical		26 Place of Dea	1 ☐ Yes 2 th (Check only on		2010
5	sicia s cert lirect	o Be	evaminer?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	Other		nce 6 Other (Spec	ifv)
ō	Phy ar this aral d	I	27. Manner of Death	28a. Date of Injury 28b. T	ime of 28c. Injury at		w injury occurred	,
O	ding th: Afte	ţ	1 Natural 5 ☐ Pending investigation	(Month, Day Year) Ir	njury Work? M 1 ☐ Yes 2 ☐ No			
S	i or Attendi after death Director: A in by the f	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, far	rm, street, factory, office		reet and Number or Ru	ral Route Number,
Division of Vital Records,		Certification:	4  Homicide	building, etc. (Specify)		City or Town	, Jiaio/	
	a Hospita 24 hours a Funeral etely filled				, death occurred at the time, date and place,			
	e Ho e Fui letely	Medical	(Check only 2 Medicel Exemi	ner: On the basis of examination and and manner stated.	d/or investigation, in my opinion, death occur	red at the time, do	ate and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number		9d. Date signed (Month	
	- > - 0		Holo 85	Coley MAD	D-19425	1	3-01-7	004
	K		30. Name and address of person who co	ompleted cause of death (Item 23a) (	Type, Print)		) 01 2	-
	0		ROBURT F P.	RY M.D-2711 L	Type, Print)  J. ROGERS AVE-B	ALTIMO	REMD ?	21209
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 1		,	
	Regist		MAR 0 2 20	MA Jenewa	A Someting .			

			For State Registrar	State of Maryla	nd / Dep <i>Ce</i>	artmer rtificat	nt of Health	and M		giene Reg. No.	2004	06519
	<b>.</b>		1. Decedent's Name (First, Middle, L	ast)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		Kathryn Pauline	Thomas		·			Februar			3:00 PM
1	Examin		4e. Fecility Name (If not institution, g.	ive street and number)		4b. City	Town, or Location	n of Death		4c. C	ounty of Deeth	
			1711 Summit Aven		. last birthday	If Linda	Haletho	orpe er 24 Hrs.	8. Date of Birtl	<u></u>		imore
	Funeral Director		5. Social Security Number 6. 215-12-2238	1 M 2 X F 83	Yrs.	Months	Days Hours		(Month, Da)	y, Year)	20 Ms	place (State or Foreign intry) aryland
		. }	Usuel Residence of Decedent			J			NOV. IC	, 19	20 112	iryrand
	nylan how		10a. State 10b. County	10c. C	ity, Town or L	ocation						10d. Inside City Limits
	Ba-fs	cto		imore			alethorpe	e				1 ☐ Yes 2 ☑ No
	death with the Maryland ms 23e or 28e-f show	Director	10e. Street and Number			10f. Zi	Code				on of What Cou	•
	s 23s	ra	1711 Summit Aven	12. Was Decedent Ever in	10 12	Was Door	21227	Origin? /So	acity Vec or No-		ted Sta	
	item item	Funeral	11. Marital Slatus  1 ☐ Never Married 2 Married	Armed Forces?	3.3.		dent of Hispanic C crify Cuban, Mexic	an, Puerto	Rican, etc.)		Black, White	, etc.
920	hours after tural', or its	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2X No Specif	fy:		S	Specify: Wh	nite
215-003	72 hours after death with the Marylar natural; or items 23a or 28a-1 show orgal Examiner man be notified at	Completed	15. Decedent's (Specify only highest g	Education trade completed)	(Give	kind of wo	al Occupation ork done during me	ost of worki	ing	16b. Kind	of Business/Ir	ndustry
2	E	Jd m	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT				C+-+	C W-	1
27	be filed within 72 ho ntal Hygiene. nd other than "natur event, the Mod Fell	S	12 17. Father's Name (First, Middle, Las	st)	1 1	Regis		ther's Name	e (First, Middle,		e of Ma	iryland
and	buld be f Mental ? arked of atic eve	o Be	Paul Nevin David						. Kayloı			
Maryland	2 should be filed with and Mental Hygiene is marked other tha aumatic event, Itel	2	19a. Informant's Name/Relationship		19b. Mail	ing Addres	s (Street and Num				Town, State, Zi	p Code)
	1 and 2 Health a Iom 27 is		Patricia A. Dist	efano Daughte	r 1106	Vern	on AVenu	e, Bal	ltimore,	, MD	21229	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic once.		20a. Melhod of Disposition  14 Burial 2 ☐ Cremation 3	20b.	Place of Disponentery, cre adowr 10	osition (Na	me of	C	Date	20c. Loca	ation - City or T	own, Slate
Ē	it. Pages dment of rtant: If it njury or o		4 Donation 5 Other (Spec	city) M	emoria.	Par	k :	3-2-	04	Elkri	dge, MI	)
Salt	Departimport import any inj		21. Signature of Funeral Service Lic	ensae	$\Delta VIII$		nd Address of Fac	TILL	orose Fu			
	⊈ ⊕ a		Camping D.	CONFI MUI			ulphur S				us, MD	21227 Approximate
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	ly one cause on each line.	ain. Do not en	i er (ne mo	of dying, such a	as cardiac d	or respiratory an	rest,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	RD 1	K E	ــــــــــــــــــــــــــــــــــــــ					BWeek
	Examiner			H 4	sert	PM	Sion					1040
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):	1	10					3//
	ate be executed hysicien and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Rev	ral	10	Mur	l				
760,	oe exe		resulting in death) cast	Due to (or as a conse	quence or):		11	llit	4			
687	physicate t	dlcal		L d		1	1-10	CC11				
Box	The law requires that the death certifica sie has been signed by the attending ph page 2 should be delached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		_				23	d. Date of deliv	rery
ĕ	death e atte	Iclai	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		□Ectopic p □ Other (s					Month	Day Year
0.0	that the de led by the a detached f	hys	9 Unknown	9□ Unknown					<u> </u>			
	res tha igned I be det	by	Part II. Other significant conditions	contributing to death but not re	sulting in the u	underlying	cause given in Par	rt I.				the cause of death?
Records,	w require been si should I	Completed							1 L Y	es 2.002	N0 3∐P10	bably 4 □Unknown
ec	a law has b e 2 st	nple							24a. Was a autop perfor	sy	24b. Were auto prior to co death?	opsy findings available empletion of cause of
									1 ☐ Yes			2□ No
Vital	Physician: The law rthis certificate has t ral director, page 2 s	o Be	25. Was case referred to medical examiner?	Hospital:	7.50/0	- 2 D	Othor		Check only or	_	DOther (Cree	<b>4</b>
ō	ing Phys	. To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury	☐ ER/Outpatie		28c. Injury at		me 5 A Resid 28d. Describe h			(y)
lon	Attending ir death. ector: After by the fune	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Year)	Injury	М	Work? 1 ⊟ Yes 2 [	□No				
Division of	er des rector by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		home, farm, si	treet, factor	y, office		28f. Location (S City or Tow		Number or Rur	al Route Number,
Õ	rs after or el Direction	Cer										
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Ex	Physician: To the best of my kr aminer: On the basis of examir	nowledge, dea nation and/or in	th occurred	at the time, date n, in my opinion, d	and place, leath occurr	and due to the or ed at the time, or	cause(s) a date and p	nd manner as s lace, and due t	stated. to the cause(s)
	thin 2 thin 2 the amplet	Med	29b. Signature and title of certifier	and manner stated.		29	c. License numbe			29d. Date	signed (Month,	Dey, Year)
	5 7 8 3 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9		1 sall	arz	7		1)21		r.,	-	1	129.2004
•	13		30. Name and address of person wh	to completed cause of death (It	em 23a) (Type	, Print)				).	5,00(2	ne <sub>e</sub>
_			SAMBANDAY	1	3455	WIL	kends A	WE.	BALT	1.40.	RE, A	10 21229
	Sta Regist		31. Date filed (Month, Day, Year)  MAR 0 2 21	32 Registrar's Sign	nature	ant s				6	•	,

			F-10	case i	State of Ma	arvland	/ Dena	rtment of	Health and	Mental H	vaiene	2001	0.5500
		•	For State Registrar		State of Ivid	ai y la li d		rificate of		Wientan 11	Reg. No.	2004	06520
	Physici	an	Decedent's Name (First, M.	iddle, Last)			1	/ m . / d	0 455	2. Date of D	eath Day	Year	3. Time of Death  1425 M
	/Medic	al .	4e. Fecility Name (If not institu	ution aive s	treet and number)	)		Ab City Town	or Location of Dea	FEBRU	111/L Y	28 2004 County of Deeth	1400
1	Examin	er	TITE TOHA	1- 1	PRINS	itasi	PITAL	BALT	muse	CITY	/	NA	
	Funeral Director	9	5. Social Security Number	6. Sex		e (In yrs. las		If Under 1 Year Months Days		8. Date of B Month, L	irth Day, Year)	9. Birthpt Count 496 MA	lace (State or Foreign try)
	land		Usuet Residence of Decedent 10a. State 10b. Cou			10c. City,	Town or Loc	/ /		· ·		10	Od. Inside City Limits
	e Many	Director	Marylons B	altik	10/2	( )	CANE	palls tem	~		1		1 □ Yes 212(No
	death with the Maryland ms 23a or 28a-f show froust be notified at	Dire	8537 W	NAX	ns la	n-a		10f. Zip Code	1133		-	zen of What Coun	lry?
	death ms 23	Funerai	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. V		Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or N	_	14. Race - America Black, White, 6	
936	within 72 hours atter death with the Marylan ane. than "naturel", or Itama 23a or 28a-f show the Madleal Exambar (Aust be notified a	þ	Never Married 2 3 Widowed 4 Divor		1 Yes 27 If Yes, Give Year or Dates:	40		Yes 25 No		no moun, orony		Specify /ac	1c
2-0	n 72 hou "nature	eted	15. Dece (Specify only hi	dent's Edu	cation completed)		(Give I	ent's Usual Occu	e during most of we	orking	16b. Ki	nd of Business/Ind	ustry
21215-0036		Completed	Elementary/Secondary (0-1	2)	Cottege (1-4or	5+)	SH	ONOT use retir	2				
	Hygi other	Be Cc	17. Father's Name (First, Mid	dle, Last)	1/					me (First, Midd		4	
ylar		70 E		rak.		vory			NEK			rrelon	/
Maryland	ges 1 and 2 should it of Health and Men if Item 27 is marke or other treumatic		19a. Inform It's Name/Relat	ionship (Ty	/	THE	196. Mailin	4	ANDS K	lurai Houte Num Rig	noer, City o NOA	Ils from	Many Mars
ē,	f Heal fem 2 other	1	20a. Method of Disposition			20b. Pla	ce of Dispos	ition (Name of satory or other pl		Date		ocation - City or To	
imo	Pages nent of ant: If I		1 Denial 2 Cremat 4 Donation 5 Othe	on 3 □ P or (Specify)	emoval from State	1 .		Emerial,	Parts 3/	6/04	-	splan r,	1 11
Baltimore	permit. Page Department o Important: If any injury or once.		21. Signatur of Funeral Sen	//			322	Name and Add	ress of Facility	tous	Lin	3	I pery Hano
	40240	4	23a. Party. Enter the disease	g, or compl	cations that cause	the deeth.		or the mode of dy	ring, such as cardia		arrest,		Approximate Interval Between
	Pnysician		shock, or heart failure.  Immediate Cause (Finat disease or condition	List only of	e cause on each i	ne. 4 <i>1</i> 11	411,	AL H	EMOLL	HAG	F		Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as	a conseque	nce of):	. 0.	1	0	-	,	1. ~ 6 ~ 6
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or as	a conseque	ince of):	PO	LYANI	F11 T1	2_	Lé	WEEKS
/	cuted	Examiner	that initiated events	1	:								
760,	te be executed ysicien and te burial-transit		resulting in death) Last	ı	Due to (or as	a conseque	ince of):						
687	physic	edicai			!								
Box (	death certificate t e attending physi od for use as the t	M/u	IF FEMALE: 23b. Was decedent pregnan	t 2	3c. If yes, outcome			Ectopic pregnan	ıcv			23d. Date of delive	•
0.8	0 0 0	by Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant a 9□Unknown			Other (specify)			-	Month	Day Year
ď	ires that the designed by the	y Ph	Part II. Other significent cor		_	out not result	ing in the ur	derlying cause g	given in Part I.	23e. Did	tobacco u	use contribute to th	e cause of death?
rds	w requires been sign should be	ed b	KENAL	FA	ILUKE					10	Yes 2	Mana 3 □ Prob	ably 4 Unknown
of Vital Records,	S S S	Completed							·		as an topsy rformed?	24b. Were auto prior to cor death?	psy findings available inpletion of cause of
al H	The page	-	OS Man case referred to ma	dient					00 Plans -4 P	1 ☐ Yes	2 <b>X</b> No		2 No
Vit		To Be	25. Was case referred to me examiner? 1 ☐ Yes _2 ☐ No		lospital:	ent 2 E	R/Outpatien	3 DOA	ther.	eath (Check online) Home 5 Re		6 □Other (Specify	()
			27. Manner of Death	ending	28a. Date of Inju	iry 2 y Year) 2	8b. Time of Injury	28c. In		28d. Describ	e how inju	ry occurred	
Division	teal feat tor: the	icati	2 Accident in 3 Suicide 6 C	vestigation ould not be	28e. Place of In	iury - At hom	ne. farm. str		□Yes 2□No	28f. Location	(Street an	nd Number or Rura	I Route Number,
Ρ	Dit o	Certification:	4  Homicide	termined	building, e	tc. (Specify)				City or 1	Town, State	9)	
	Fe A	Medical (	29a. Certifier 1 Cer (Check only one) 2 Med	tifying Phy lical Exami	sician: To the best ner: On the basis	of examination	ledge, death on and/or inv	occurred at the estigation, in my	time, date and pla- opinion, death oc	ce, and due to the curred at the tim	ne cause(s) e, date and	) and manner as st d place, and due to	ated. the cause(s)
	To the Hos wit in 24 ho To the Fun completely	Med	29b. Signature and title of ce	rtifier	and manner s	ated.		29c. Lice	nse number		29d. Da	te signed (Month,	Day, Year)
	- > - 0		* ennig	in	1 Ven	1 Con	Mi	LE:	5000	)	FEB	RUALV	28,2004
	7		30. Name and address of pe	-		death (Item :	23a) (Type,	Print)	-10-	4	2 11		28,2004 M) 21287
		ate	31. Date filed (Month, Day,		7 ( C. Regist	rar's Signatu	ire O	/V . W.	uite.	JT . [	Se It	mare, 1	111 21287
	Regist		MA		2004	Wieles-	N.	podi					

ORIGINAL

		For Stete Registrar	State of Ma	-		nt of H	lealth a	nd M	ental Hyg	iene 19. No. 2 (	004	0652
Physicia /Medica Examine	n al	1. Decedent's Name (First, Middle, Las  2. Decedent's Name (First, Middle, Las  4a. Facility Name (If not institution, give	01/50M				Location of		2. Date of Death	Day 23 20 4c. County		3. Time of Death
Funeral Director		Lorien N/H  5. Social Security Number 6. Security Number 1  215-50-9898 1  Usual Residence of Decedent	ex 7. Age	(In yrs. last birt		umbi: r1Year Days	al If Under 2 Hours	Min.	8. Date of Birth (Month, Day, 8-15-	Howa 1 <sup>92</sup> 1		ace (State or Foreign fry) Texas
ne Maryland 8a-f show		10a. State 10b. County  Md Howa	rd	10c. City, Town	ia							Od. Inside City Limits 1 ☐ Yes 2 ☒No
th with th	Funeral Director	10e. Street and Number 6234 Cedar Lane	2		10f. Zi	2104	44		10	og. Citizen of V US		try?
within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show the Madral Examiner must be notified at	2	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent & Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1 \( \subseteq Yes		ispanic Orig n, Mexican, Specify:	in? (Spec Puerto F	cify Yes or No- lican, etc.)		ce - America ck, White, e	
VIXID-003  within 72 hours jiene. rithan "natural", the Model Ex.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th grade	de completed) College (1-4or 5		Decedent's Usu (Give kind of w life. DO NOT	al Occupa ork done d use retired	during most )	of workin	g	16b. Kind of B		ustry
be fill be fill by od out	To Be C	17. Father's Name (First, Middle, Last) Plez Saunders						Со	(First, Middle, M		, 	
Dattimore, Marylis permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marks any niury or other traumatic pages.	The second second second	19a. Informant's Name/Relationship (7  Robert Baker —  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify	Son Removal from State	20b. Place of cemeter	0324 Bro	econs	shire	Road		sville :	Md City or To	21029 wn, State
Balti permit. Depertm Importa any nau		21. dignature of Funeral Service Licer	S- Ke	12	22. Name a		4300	Waba	sh Aven		to, Mo	d 21215
ysicië	Ical Exam	23a. Part1. Enter the disease, or compandot, or heart failure. List only of the second	a. Due to (or as a b. Due to (or as a c.	e. a consequence of a consequence of a consequence of	of): of):		De	hy	itia drat	LON		Approximate Interval Between Onset and Death
RECOIDS, P.O. BOX 08  The law requires that the death certificat the has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗍 Fetal déath	3 □Ectopic p 5 □ Other (s						te of deliver	y Day Year
w requires that been signed by should be deta	<u>م</u>	Part II. Other significant conditions or	entributing to death but	nt not resulting in	the underlying	cause give	en in Part I.		23e. Did tob			e cause of death? ibly 4 ∐Ùnknown
	Completed				7 4				24a. Was an autopsy perform	ed?	Were autop prior to com death? I  Yes	sy findings available apletion of cause of
Or VICA Physician: this certific ral director,	To Be	1 1 185 23 140		nt 2 ER/Out		-	er: 4 Nur	sing Hom	(Check only one e 5 □ Resider	nce 6 Oth		)
<b>=</b> 5 € 6	Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	280. Place of Inju	ry - At home, far	njury M		rat ⟨? Yes 2 □ N	lo	3d. Describe how	eet and Numb		Route Number,
	edical Cert	29a. Certifier (Check only 2 Medical Exam	building, etc ysicien: To the best of iner: On the basis of	f my knowledge, examination and	, death occurred	at the tim	e, date and	place, ar	City or Town,  and due to the caid at the time, da	use(s) and ma	inner as sta	ited. the cause(s)
To the within 2 To the complet	Med	29b. Signature and title of certified	and manner sta	<b>М</b>	29	c. License	number 372	.11	ţ	d. Date signed		
צ		30. Name and address of person who archall Freedom	completed cause of de	eath (Item 23a) (	Type, Print)	UMB	A, N	11)	21045		•	
Stat Registra	-	31. Date filed (Month, Day, Year)	32. Registre	's Signature	COL And	13						

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dev Year February 27 2004 0530 BLANCHE L. WYATT 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Name (If not institution, give street end number) STELLA MARIS HOSPICE AT MERCY BALTIMORE N/AIf Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) Deys 1□M XIXF Yrs. 432-30-2893 AUGUST 21,1920 Usuel Residence of Deceden 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits DUNDALK MD BALTIMORE 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 152 CARVER ROAD 21222 USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2XXMarried 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE'S AIDE HEALTH 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HAMPTON HILL ELLA HERON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) JAMES WYATT/HUSBAND 152 CARVER ROAD BALTIMORE, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 万 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST CEMETERY 3-5-04 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. ton 1701-31 LAURENS ST. BALTIMORE, MD 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) provolal accide Due to (or as a consequence of) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? **4** Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 No 1 Tyes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospics 28h Time of 28d. Describe how injury occurred

sician and burial-transit certificata be axecuted Division of Vital Records, P.O. Box 68760, attanding physician for use as the buria Hospital or Attanding Physician: this After after daath. Director: To the Hospital or Attar within 24 hours after dat To the Funeral Director completely filled in by th

**Physician** 

/Medical

Examiner

Director

Funeral

2

Completed

Be

**Funeral** 

Director

filed within 72 hours aftar death with the Maryland Hygiene. ther than "natural", or flems 23a or 28a-f show

parmit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylar Department of Haalth and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at

**Physician** /Medical

Examiner

Examiner

Physician/Medical

þ

Completed

Be

Medical Certification: To

Rlanche

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 1 Naturel 5 Pending

2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide

301 ST.

Registrer's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

LCVID

30. Name end address of person who complet cause of deeth (Item 23e) (Type, Print)

Risebero

2004

02

29c. License number

29d. Date signed (Month, Day, Year) 2004

J40854

PL.

Baltimore md. 21202

State

Registrar

DHMH 16 Rev 6/95

PAUL

	1 - For State of Maryland / Department of State of Maryland / Department / De	artment of Health and M	lental Hygiene	NNI 06522
Physician	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
/Medical	Helen Katherine Wioncek  4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	February 27,	2004 5:00 A M
Examiner	Upper Chesapeake Medical Center	Bel Air		ty of Death
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	arford  9. Birthplace (State or Foreign Country)
Director	Usual Residence of Decedent		July 25, 1921	New York
with the Maryland a or 286-f show the notified at Director	10a. State 10b. County 10c. City, Town or Lo.	cation		10d. Inside City Limits
with the Marylar to 28e-1 ehow	Maryland Harford Bel 1			1 ☐ Yes 21€ No
with to be or 2 lbs or 1 Direct	10e. Street and Number  1025 Southern Drive	10f. Zip Code	10g. Citizen of	What Country?
5 Suffer death v		21014  Vas Decedent of Hispanic Origin? (Spef Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- 14. Ra	USA Ice - American Indian,
5000 036 urs after alt, or ite	1 Never Married 2 Marned 1 Yes 2 No	r Yes, specify Cuban, Mexican, Puerto I □ Yes <b>3</b> ૄ□ No <i>Specify:</i>	Rican, etc.) Bis	ack, White, etc.
0500 15-0036 77 hours after death w "natural; or items 23a refleat Examinat must	3 Wildowed 4 Divorced Year of Dates:	ent's Usual Occupation		White
21215-0 ed within 72 ho ygjene. iner than "natur. it, the Medical it.	(Specify only highest grade completed) (Give	kind of work done during most of workir DO NOT use retired)	ng 166. Kind or i	Business/Industry
led will led will led will led will led will led will led the the left led the led the left led	12 Homen	naker	Own 1	Home
Maryland 2121. d 2 should be filed within th and Mental Hygiene. t? is marked other than " treumatic event, the Men. To Be Comple	John J. Jordan		(First, Middle, Maiden Suma	me)
aryla should and Men ond Men on marke umartic.		g Address (Street and Number or Rural	L. Corcran	. State. Zip Code)
o 500  ire, Maryland 21215-0036  s 1 and 2 should be filed within 72 hours after death with the leath and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or other treumatic event, the Medical Examiner must be other treumatic event, the Medical Examiner must be To Be Completed by Funeral Di		Southern Drive, B		
altimore, altimore, mil. Pages 1 a portment of Hee portant: If from y injury or othe	1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State	natory or other place)	ate 20c. Location	- City or Town, State
Itim it. Pa		Service Corp. 2-28		, Maryland
Baltimore, Maperinit Pages 1 and 2 s Department of Health at Important: If item 27 is any injury or other treugner.	13	Name and Address of Facility Comas Funeral Home 17 Cokesbury Road	, Abinadon, Mi	21009
	23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cadse on each line.  Immediate Cause (Final			Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	HORY FAILURG	Nacional Control of the Control of t	/ WOEK
Examiner	CUPIANIC MESTE	UCTIVE PULMON	LARY DISTAS	E 1923
sit sit	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury			
60, Seaund be executed burial-transit all Examine	resulting in death) Last  Due to (or as a consequence of):			
3760 3760 ate be enysician he buria	<b>L</b> <sub>d</sub> .			
c 68 ortifical ing physical the as the Media	IF FEMALE:			
P.O. Box 68 hat the death certifica dby the attending philetached for use as the Physician/Media	23b. Was decedent pregnant in the past 12 menths?	Ectopic pregnancy		ite of delivery onth Day Year
P.O. that the de detached detached	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)	IVIC	Jay Fear
Hecords, P.O. Box 6876(   Pecords, P.O. Box 6876(   I law in quires that the death certificate be the has been signed by the attending physicial aggle 2 should be detached for use as the burnompleted by Physician/Medical	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.		tribute to the cause of death?
ecords, law raquires law raquires 2 should be uppleted by	ATRIAL FIBRILLATION			3 ☐ Probably 4 Ø Ønknown
	DIABETES MELLITUS		autopsy performed2	Were autopsy findings available prior to completion of cause of death?
Hovital Vital Vital Vician: Tr Certificate Fector, pag	25. Was case referred to medical	26. Place of Death	<u> </u>	1 ☐ Yes 2 ☐ No
F sp sin 5	1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ☐ ER/Outpatient	3□ DOA Other: 4□ Nursing Hom	e 5 ☐ Residence 6 ☐ Oth	er (Specify)
Affer fune	27. Manper of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	28c. Injury at 28 Work? M 1 ☐ Yes 2 ☐ No	3d. Describe how injury occur	red
Division o  Division o  tel or Attending Pr rs after death. el Director: After tr led in by the funeral  Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)		of Location (Street and Numb	er or Rural Route Number,
Dio Dio Diospital or hours after hours after hours after hours after cai Cert			City or Town, State)	
Division  Division  Division  To the Hospitel or Attent within 24 hours after deatt  To the Funerel Director: completely filled in by the	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death of the best of my knowledge,	occurred at the time, date and place, an stigation, in my opinion, death occurred	d due to the cause(s) and ma d at the time, date and place,	anner as stated. and due to the cause(s)
To t To t	29b. Signature and title of centrer	29c. License number	29d. Date signed	d (Month, Day, Year)
11)	20 Name and address of source who are likely as and address of source who are likely as and address of a source who are likely as	DX5017	FEBRUA,	RY 27, 2004
	30. Name and address of person who con leted cause of death (Item 23a) (Type, Print of the Control of the Contr	D25017 EVENUE BEL 41	R MB 21	014
State Registrar	31. Date filed (Month Park ear) 2 2004 32. Resistrar's Signature	rester		

			State of Maryland / D State of Maryland / D	epartment of Health and M Certificate of Death	lental Hygiei Reg.	ne2004	06524
	D		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		ELIZABETH WILKINSON		02	26 2004	241 PM
	Examir		la. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	, , 212-	4c. County of Death	0
			PRESBYTERIAN HOME OF MARYLAND, I	NC TOWSON, MARYLA	1NG 04 1	3 ALTIM	ORE
	Funeral Director		5. Social Security Number 6. Sex 7. Age (in yrs. last birti	nday) If Under 1 Year / If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye.	9. Birthple	ece (State of Foreign
-	D .		Usual Residence of Decedent         10c. City, Town           10a, State         10b. County         10c. City, Town	or Location		10	Dd. Inside City Limits
	ehow	5	Maryland Baltimore	Towson		10	1 ☐ Yes 2 ☑ No
	ith with the Maryla 23a or 28a-f ehor	Direct	10e. Street and Number 400 Georgia Court	104 Zip Code 21204	10g.	Citizen of What Countr USA	4.1
396	ltame	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 N No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spell f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
Maryland 21215-0036	ithin 72 hours after. ne. hen "neturel", or	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1·4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of workil life. DO NOT use retired)	ng 16b	. Kind of Business/Indu	ustry
2	led w tygien her ti	S	17. Father's Name (First, Middle, Last)	Social Worker	(First, Middle, Maid	eterans Adr	ninistration
ylanc	s 1 and 2 should be filed within Health and Mental Hygiene. Item 27 is marked other than other traumatic event, Ite M	То Ве	Robert G. Lovett	Eli	izabeth Mo	Lemore	
Man	nd 2 sho alth and 27 ie ma r traum		19a. Informant's Name/Relationship (Type, Print) 19b.  Robert Pierson/Personal Rep. 201	Mailing Address (Street and Number or Rura L. B. Baltimore Street	Route Number, Cit Suite 14	y or Town, State, Zip ( +20 Baltim(	<sup>Code)</sup> 21202 ore, MD
Baltimore,	8 = 5		20a. Method of Disposition 20b. Place of cemetery	A CONTRACTOR OF THE PARTY OF TH	ate 20c.	Location - City or Town	vn, State
Baltir	permit. Pa Departmen Important: any injury		21. Signature of Funeral Sarvage Jenispe	Cremation Society of	of Marylan	nd, Inc.	
	40200		Dawn F. McDonald  23a. Part1. Enter the disease, or complications that caused the death. Do not	299 Frederick Road			28 Approximate
H	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a	heart failure			Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	obstactive pulmon.	m dises	h	7 7 7 5
8760,	cate be executed physicien and ithe burial-transi	dical Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of d.	():	,		
P.O. Box 6	Hospital or Attending Physician: The law requires that the death certific 4 hours after death. Funeral Director: After this certificate has been signed by the attending p tely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month D	y Day Year
	quires that n signed b utd be deta	þ	Part II. Dther significent conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	1.7
Division of Vital Records,	The taw requi	Completed			24a. Was an autopsy performed?	prior to comp death?	sy findings available pletion of cause of
ital	ysician: The is certificate hadinector, page	a)	25. Was case referred to medical	26. Place of Death		40 12 163 2	.23 140
>	ysici is ce direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	patient 3 DOA Other: 4 Nursing Hon	ne 5 🗌 Residence	6 ☐Other (Specify)	
0	ding Ph n. After th funeral	Ë	27. Manner of Death 28a. Date of Injury 28b. Ti 1 ⊠Natural 5 □ Pending (Month, Day Year) Inj		8d. Describe how in		
ivision	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: Atter the completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Street City or Town, Sta	and Number or Rural I	Route Number,
٥	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier  (Check only cone)  2□ Medical Examiner: On the basis of examination and	death occurred at the time, date and place, a	and due to the cause	(s) and manner as stal	ted.
	the H nin 24 the F	ledi	and manner stated.				
	Viith Con	Σ	29b. Signature and title of certifier  Attending n	29c. License number 0 370/6		Date signed (Month, Di	*
	V		30. Name and address of person who completed cause of death (Item 23a) (The net I m. Green, no 6701 N. Char		Himor, 2	0 11209	
	Sta Registr	-	31. Date filed (Month, Day, Year)  MAR 0 2 2004  32. Registar's Signature	Soule			

_			1 - For State Registrar	State of Mary		partment of Prtificate of			iene g. No. 20	04 0652!
	Physic /Medi		1. Decedent's Name (First, Middle, Las Ann Elizabeth I	Wimbish				2. Date of Death Month 02/11/2	Day 2004	Year 3. Time of Death 9:11pm M
	Exami		4e. Fecility Name (If not institution, give Southern Marylar  5. Social Security Number 6. Se	nd Hospital	n yrs. last birthday)	Clin	n, or Location of Death nton MD  ar   If Under 24 Hrs.		4c. County of	e Georges
	Funeral Director		224-72-8947 Usual Residence of Decedent		56 Yrs.	Months Day			947	9. Birthplace (State or Foreign Country) VA
	death with the Maryland ma 23a or 28a-f ehow rmust be notified at	Director	10a. State MD 10b. County Prince G		c. City, Town or Lo	ocation	Waldo	rf		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	a 23a or 2		10e. Street and Number 11485 Avene1 Cot				20602			SA
980		by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed ♣ □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ※ No lif Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2XXX	of Hispanic Origin? (Spuban, Mexican, Puerto No Specify:	pecify Yes or No- to Rican, etc.)		- American Indian, White, etc. black
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[ ] [ ] [ ] [ ] [ ]	filed Hygi ther	To Be Cor	12 17. Father's Name (First, Middle, Last) Robert Harrison	0	Par	king En		me (First, Middle, M. 288a Adams	laiden Sumame)	rnment
Maryland	27 tr	F	19a. Informant's Name/Relationship (T) Yolanda Parker /			ing Address (Stree 1206 Ment	et and Number or Ru			ate, Zip Code)
-//-0 र्म Baltimore,	S - = 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ (Specify)		Ob. Place of Dispo cometery, cren Smith Ch			Date 20 02/18/200		pelham, NC
2-// ■ Bal	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Licens	Victor D	oda S 15	OUL E. Fo	Funeral Ho ort Ave.,	Baltimore	∍ MD 212	230
•	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. CONCES	STIVE (	er the mode of ay	ying, such as cardiac		t,	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. PULMON Due to (or as a cons	nsequence of):	FIBRO				
8760,	ate be executed hysician and the burial-transit	al Exami	Cause (Disease or injury that initiated events resulting in death) Last	c. ARTCA  Due to (or as a cons  d. DIASE	nsequence of):	DCCLUS MELLI	TUS	· MCett	LEG	-
) D. Box 687	eath certificate attending phy for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome of preductive birth 2 F 4 Pregnant at time of 9 Unknown	egnancy Fetal death 3	Ectopic pregnance Other (specify)			23d. Date of Month	,
In C	quires that the d n signed by the ald be detached	by	Part II. Other significant conditions con				given in Part I. PLOTENCY	7		ite to the cause of death?
Sh, A Vital Record	The law requires te has been sign bage 2 should be	Completed				17		24a. Was an autopsy performe	24b. Werd prior deat	re autopsy findings available r to completion of cause of th?
	Physician: The lav this certificate has ral director, page 2		25. Was case referred to medical examiner?  1 Yes 2 No		2 ☐ ER/Outpatient	nt 3 DOA Ott	the second	th (Check only one)	2No 1□	Yes 2 <b>∑</b> No
	Jing After fune	Certification; 1	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	r) 28b. Time of Injury	M 1	ury at ork?	28d. Describe how	injury occurred	
Z :	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined  29a. Certifier Certifying Physical Certification	28e. Place of Injury - Al building, etc. (Spe	knowledge death	a occurred at the ti	time date and place	City or Town, S	State)	or Rural Route Number,
	To the Ho within 24 P To the Fu completely	Medical	(Check only one) 2 Medical Examin	iner: On the basis of exami and manner stated.	ination and/or inve	vestigation, in my o	opinion, death occurr	red at the time, date	and place, and	due to the cause(s)
	b		30. Name and address of person who col	ompleted cause of death (	Itam 23a) (Type, I		8128		2-12-	. ,
	Sta			0192 OXON 1 B2. Registrar's Sig	HILL RO	-	ITE 500 C	JXON HIL	L MO	20745
100	Stat Registra	10	MAR 0 2 2004	82. Registrar's Sig	gnature Angel	£ 8 ·				

State of Maryland / Department of Health and Mental Hygiene 2004 06526 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da FEBRUARY Day **Physician** WLLSON 4 54 A M DENISE 24 12004 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPINAL BAUTIMORE BALTIMORE CITY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 🗲 **Director** 2355 30 MARY / AND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location itame 23e or 28a-f ehow 10d. Inside City Limits the Medical Exacutour must be notified at 1 ☐ Yes 2 No Directo PAYKUI1/E MARY / Aus 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Usin 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Never Married 2 ☐ Married 1 Yes 2 No It Yes, Give Year or Dates: 9 1 Yes 25 No þ Specify: 3 Widowed 4 Divorced "natural", Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT upte retired) 16b. Kind of Business/Industry ate then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Book Koopen GnRS other Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event QDCs. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILSON ZEVOM & KEGINA UE 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Boute-Number, City or Town, State, Zip Code) MOTHER kville, MELBY Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3 Date -04 →Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Un the TONG Green de 21. Signature Funeral Service Licensee BATHUR, LE Mun stown Led 21215 23a. Pa vi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pock, or bean failure. List only one cause on each line. Approximate Onset and Death mediate Cause (Final Physician disease or condition resulting in death) ARRHUMHILA HIMTES /Medical Due to (or as a consequence ot) Examiner CORDINARY ARTSEY DISTAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): attending physicien and for use as the burial-transit The law requires that the death certificate be executed CONGESTIVE ITENET resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical CHEONIC OBSTEUCTIVE EARS PULMONTRY IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day 4□Pregnant at time of death Year 5 Other (specify) been signed by the a should be detached o. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy of Vital 1 Yes 2 No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2€ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death After t Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending Injury 1 Natural 5 Pending after death. 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funerei C 29a. Certifier 122-Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30950 MS F/2 BRUARY 24, 2004 30. Name and address of person who completed cause of death yem 23a) (Type, Print) 5601 LOCH PAVEN BOULEVARD, BALTIMORE, MD 2123 ROMAN KOSTEN BIAK MD, GRONSWARTHWHOSTITAL 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar MAR 0 2 2004

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	1 = For State Registrar				Certific				Reg. No	200	4 (	16527
Physician	1. Decedent's Name	(First, Middle, Last)	EL WIL	LIAD	س			2. Date of De Month	ath Da		ir .	ime of Death
/Medica	MARCE					ity Town or	Location of Death	tEB =	2/	Ounty of D		, - JO WM
Examine	7906 D	UL HILL	11 11.		1 .	IND 50	h.			Altipo		
Funeral	5. Social Security Nu	mber 6. Sex	7. Age	e (In yrs. last l	birthday) If U	nder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da				State or Foreign
Director	2/3 32 49 Usuel Residence of I	9	M 287F	66	Yrs.			DEC 20		37 M		20
/land		10b. County		10c. City, To	own or Location						10d. Ins	side City Limits
e Man	Maylono	N/A		B	BAHA	T/C					)	Yes 2 □ No
with the Ma	10e. Street and Num		ork Ave	#30	a 6 10f	. Zip Code	207			izen of What	Country?	
buts after death with the Maryland art. or thams 23a or 28a-f show Exam are multiple at the Exam are in the Example of the Exa	11. Marital Status	WIST D	2 Was Decedent F		13. Was D		spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No		14. Race - A		ian,
in the second		d 2 Marned	Armed Forces? 1 ☐ Yes 2 2 1 If Yes, Give	40		specify Cuba	n, Mexican, Puerto Specify:	Hican, etc.)		Black, W	1 ,	
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C - CI -	Dennick	Durin B			1900 7	UNHI	122 VIII	Age Car	cile	4-303 WI	NOSON	MILL, Me
ges 1 and t of Healt if Item 2 or other	20a. Method of Dispo	osition	amoval from State	20b. Place ceme	of Disposition (	(Name of or other place	1	27/04		ocation - City		
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permit. Page Department Importent: eny Injury once.	21. Signature of Jun	eral Service License	9		22 Nam	e and Addres	s of Facility	of Lun	20	MI A	IN EAST	March
	3a. Part1. Enter the	dise se, a complice fail re. List only on	cations that caused	the death. D			g, such as cardiac	or respiratory a	rrest,		Appro	oximate al Between
Physician	Imm te Cause (F	inal	Rey	1. al	lai	lure						and Death
/Medical Examiner	resulting in death)	(	Due to (or as	a consequenc	ce off:	1	rtense	21-			20	v.C
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le be executed /sician and e burial-transit		ist	Due to (or as a	a consequenc	e of):							
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	IF FEMALE: 23b. Was decedent	oregnant 23	3c. If yes, outcome							23d. Date of	delivery	
death cert le attendin	in the past 12 m 1 □ Yes 2 🜠	nonths?	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			ic pregnancy (specify)				Month	Day	Year
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Ital or ras afte ras Dir led in			building, etc	(Specify)				Ony or 10	wir, Otate			
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page Madical Certification: To Re Com-	29a. Certifier (Check only one)	Certifying Phys Medical Examin	ician: To the best of er: On the basis of and manner sta	examination a	lge, death occur and/or investiga	red at the tim tion, in my op	e, date and place, pinion, death occur	and due to the red at the time,	cause(s) date and	and manner I place, and d	as stated. ue to the ca	use(s)
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X	30. Name and addre	ss of person who con	npleted cause of de	eath Item 23a	a) (Type Print)	1+,	MORE	MX		7.	120	1
State	11 1 10	, Day, Year)	32. Registra	ar's Signature	NH	-1/1	MUKL	,,,,			70	1
State Registrar			2 2004	Moscie	J. St.	beach						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Shari Joyce Anderson 11308M 11 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deeth HOSPITA! NORTH APRINDER CILEN BURNOLE trun Die ANNE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Dec. 12) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign Country) Maryland 217-52-4630 1 M 2 X F Director 1961 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with lihe Marylan Department of Health and Mental Hygiene Importent: if item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Exacultational profiled at SDB. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Director Glen Burnie 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7892 Crain Hwy. 21061 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No Specify: þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ronald Orbany Dolores R. Kraus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Lowman/Friend 7892 S. Crain Hwy Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Metro Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Baltimore, MD 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetel dea 4 Pregnant at time of death 3 Ectopic pregnancy ģ in the past 12 months? Month Year 5 Other (specify) detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ After this certificate has been si funeral director, page 2 should it 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 2 Accident 1 ☐ Yes 2 ☐ No the Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral D 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 500 ct 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hen Busme doch MO setal 10 31. Date filed (Month, Day, Yeer) State Registrar 2004

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician**  $P^{M}$ February 2004 1:30 6, Burger /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 17225 Amber Drive Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 X F 219-12-0519 80 25,1923 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location ir than "natural", or Itema 23a or 28a-f ehov the Medical Examiner must be notified at 1 XYes 2 □ No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17225 Amber Drive U.S.A. death v 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth eny jury or other traumatic event soics. McKinley Shank Lilia Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rolland J. Burger/Son 10707 Oak Forest Dr. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 2/12/2004 Hagerstown, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 5. Mark 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DOKIL **Physician** /Medical **Examiner** 110 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2/2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribut to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 Proba ly 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Monner of eath neral Director: After the filled in by the funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item-23a) (Type, Print) BASO 1110 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 1 Registrar

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To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fune

29a. Certifier (Check only one) 29b. Signaty

2 Accident 4 Homicide

1,300 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6 Could not be determined

29c. License number O.C.M.E 29d. Date signed (Month, Day, Year) FEB. 10, 2004

(Street and Number or Rural Route Number

leted cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medicai Certificati

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06533 Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) Year **Physician** Les1ie Beaver February 15, 2004 1:38 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Reeders Memorial Home Boonsboro Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 ☐ F Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 183-12-1878 Yrs. Director April 27,1918 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other then "naturel", or items 23a or 28a-f showent, the Medical Examiner must be notified at 1X Yes 2 □ No Directo Washington Boonsboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 141 S. Main St. 21713 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I ☐ Yes 2 ☒ No if Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o Mental John K. Beaver Mae Ovelman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 21742 19a. Informant's Name/Relationship (Type, Print) Department of Health Importent: if item 27 55 E. Washington St. Elizabeth Ct. #512 Hagerstown Naomi R. Beaver/Wife or other 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 2/19/2004 Hagerstown, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee Mark 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** meumones /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diesase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 3/2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fu death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

-2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Guedenet 21 Wy and Dr. 301-432-2222 <u>Keedysville, MD 21756</u>

State Registrar

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

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			1 - For State Registrer	State of Marylan	d / Depa		ealth and I	Mental Hyg	_	
			Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death
	Physici		Charles Hopkins	Bramble				Month Feb	Day Ye	ear 0760 M
	/Medio Examin		4a. Facility Name (If not institution, give si	treet and number)		4b. City, Town, or	Location of Death		4c. County of [	
	LX		Dorchester Genera	al Hospital		Cambr:	idae		Dorch	ester
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
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$\neg$	fanyla sho ed al	5	MD Dorches			Hurl	ock			1 ☐ Yes 2 ☑ No
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0	ng Ph ter th neral		27. Manner of Death  1 △ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury Worl	y at k?	28d. Describe ho	w injury occurred	
<u></u>	andir eath. or: Al	catic	2 Accident investigation			M 1 🗆	Yes 2 ☐ No			
Ĕ	or Att after de Diract I in by t	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st fy)	reet, factory, office		28f. Location (St. City or Town	reet and Number o i, State)	or Rural Route Number,
	ours a		29a. Certifier 12 Certifying Phys	sicien: To the best of my kno	audada daat	h accurred at the time	no, data and place	and due to the ca	useds) and manne	or ac stated
	To the Hospital or Attanding Physician: The law within 24 hours after death.  To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	Medical		ner: On the basis of examina and manner stated.						
	o the	Me	29b. Signature and title of certifier	>.		29c. License	e number	25	9d. Date signed (N	fonth, Day, Year)
	- > P 0		Matterlo	les		1)2	6388	3	Fes 8	3, 200 4
			30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type,	Print) 8/1/12 /	1/	/ /		16
			Michael JFAC	lden AD		E11/12 /	TUC /ta	erlock	ma 7	1643
	Sta Regist		31. Date filed (Month, Day 1	2013 ARegistras Signa	ature J	And	•			
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State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar 06535 Certificate of Death 2. Date of Death Month 1. Decedent's Name #First, Middle, **Physician** 02 07 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A MO If Under 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 6. Sex last birthday) **Funeral** Months Days Hours Maryland 1**X** M 2□ 82 Yrs. 214-72-1233 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 USA 102 Victor Parkway Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medital Examina. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farming Self Employed 4th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ethel Galloway Thomas Brooks ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor Parkway Annapolis, Md. 21403 Isabella Fuller (Neice) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2/13/04 Baltimore, Md. 21. Signature of Funeral Service Licensee Name and Address of Facility n. Reese & Sons Mortuary, 21 West St. Annapolis, Md. Kase MOO 8 Lavry D. Approximate Interval Between On, et and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such is cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?

1 Yes 25 No Month 힏 Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 9 Unknown 9 Unknow þ s been signed b 23e. Did tobacco use contribute to the cause of death? Part I **Other sign ficant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy this certificate 1 Yes To the Hospital or Attending Physician: funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 3□ DOA P 1 Tyes 2 ER/Outpatient 28a. Date of jury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Diractor: A investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier m 23a) (Type, Print) 30. Name and Horpita 31. Date filed (Month, Day, State FEB 1 8 2004 Registrar

	RPD		For Amend Item#2:   State Registrar unpend item#2	a, Fer ME, (830), 3a, 27, 28a-f. Per	land/Dep +/30/0462 ME.08292	artment of	Health and	Mental Hygi	ene 200L	06536	
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	Funeral		5. Social Security Number 6. S		yrs. last birthday,	Months Day			Year) 9. Birth	plece (State or Foreign Intry)	
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)	De 💌	-	Usuel Residence of Decedent  10a. State 10b. County	100	c. City. Town or L	ocation				10d. Inside City Limits	
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Maryland	01 62 68 68		19a. Informant's Name/Relationship (						City or Town, State, Z.		
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Baltimore,	permit. Pages 1 at Department of Hea Important: If item eny injury or othe		20a. Method of Disposition  M⊠Burial 2 ☐ Cremation 3 ☐	Removal from State		matory or other p					
Ē	Pag ment ant:		* 4 □ Donation 5 □ Other (Special	y) E				19/04	Annapolis	s, Md.	
<u>m</u>	epart nport ny in		21. Signature of Funeral Service Lice	nsee	- 1	2. Name and Add		ne Morti	ary PA		
	20539		Zavry A. Acese M083 Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21101  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate								
3760,		Ical Examiner	d								
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	res that igned by be deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?			
Vital Records,	w require been sig should b							1 Yes 2 No 3 Probably 4 Unknown			
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0			27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury <b>fourth</b> Day Ye	of 28c. Ir	28c. Injury at Work?		28d. Describe how injury occurred			
.0		atle	2 Accident investigation	n 2/7/04	5:55		Yes 2 No	unknown			
Division of	er de recto	Certification:	3 ☐ Suicide 6 Could not determine	building, etc. (Specify)			СӨ		ocation (Street and Number or Rural Route Number, City or Town, State)		
Q	tel or rs afte al Dir ed in	Cer						710 J Newtowne Dr, Annapolis, MD			
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical									
	To th To th comp	N	29b. Signature and title of certifier 29c. License number					29d. Date signed (Month, Day, Year) February 8, 2004			
			O.C.M.E.			F					
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANA RUBIO, MO 111 Penn Street, Baltimore, Maryland 21201								
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Redistrar's			•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 State Registrar Unpend Item#23a,27,Per ME,C829,3/12/extellicate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 09:50 AM February 24, 2004 Bardwell Stephen Pau1 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 10XM 2□F Yrs. July 11, 1961 Massachusetts Director 018-50-6119 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Itams 23a or 28a-1 show any injury or other traumatic event, Ira Medical Expirition must be notified at once. 1X Yes 2 No Norfolk Virginia Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23503 U.S.A. 540 West Ocean View Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Marned White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Supplies Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Skulley Bardwell Sandra 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2205 Boston Road C-27, Wilbraham, MA Richard Bardwell/ Father Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)
Springfield Springfield, 3/2/2004 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Cemetery and Crematory
22. Name and Address of Facility Massachusetts 21. Signature of Funeral Service Licenses Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to lor as a consequence of Examiner attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ned by the Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, been signe should be δ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an autopsy has certificate 2 No 1 Yes r. After this certification funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient **2**O€R/Outpatient 3□ DOA 1 X Yes 2 ☐ No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred of or Attending Patter death. Certification: Iniun 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 [ ] Homicide To the Hospitel o within 24 hours aft To the Funerel Di completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. February 25, 2004 ws 30. Name and address of person who completed cause, 1/eath (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

IMEVOURE Millin 31. Date filed (Month, Day, Year) 32. Registrar's Signature 6 2004

THOMAS COLDWELL  46. Feelity Name of the institution by a street and number)  46. Feelity Name of the institution by a street and number)  46. Colly Town, or Location of Death  TALBOT  FUNDAL HOSPITAL  5. Social Security Number  5. Social Security Number  6. Sex	Dhusia		1. Decedent's Name	e (First, Middle, La	23a,27,28a	Let I	<u> و ۵۰۷۷ و س</u>	J 7 0102			2. Date of D		2001	3. Time of Death
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The part of Name (First, Meddie, Last)  FRANK COLDWILL  FRANK	Mary Filed	tor	MD	QUEEN	ANNE		CENTRE	VILLE						1X Yes 2□N
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend #7,16a,16 State of Maryland / Department of Health and Mental Hygiene 200 L. Registrar WCHD/SH 2/17/04 per FH Certificate of Death Reg. No. 06539 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Denise Horst Crawford 2004 ehreldry, 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3 Whittier Heights Washington Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 F 215-64-0248 Director 50 Nov. 4, Maryland Usual Residence of Decedent 1953 NOV. 4. with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or items 23a or 28a-1 shov the Medical Examiner must be notified at Director 1X Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Whittier Heights 21742 death USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Retail Elementary/Secondary (0-12) College (1-4or 5+) <del>Retired</del> Expediter Potomac Center nd 2 should be filed alth and Mental Hygid 27 is marked other r traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ray Allen Horst Mary Louise Horst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Carroll M. Crawford/Husband 3 Whittier Heights, Hagerstown, Maryland 21742 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State ŏ permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 2/14/2004 Hagerstown, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licenses 1601 Pennsylvania Avenue, Hagerstown, Md. 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast **Physician** 40 ar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Exami Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ed bluods 1 Tes 2 X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an Jas autopsy perform 2 X No 2 □ No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ovent Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 2 No ٩ 3□ DOA This WO. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of or Attending Injun 1 Natural 5 Pending after death. 1 Tes 2 No 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) down Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's/Signature

DHMH 17 Rev 1/2001

Registrar

13

State of Maryland / Department of Health and Mental Hygiene 2004 06540 Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Catherine Irene COMPTON 2004 Feb. 11, 6:00 p. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Clearview Nursing Home Hagerstown Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖾 F 53 Yrs 220-54-4787 Director June 10,1950 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Funeral Director W. Va. Berkeley Berkeley Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Green Street 25411 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 ☐ Widowed 4 🗓 Divorced "natural", Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than " Elementary/Secondary (0-12) College (1-4or 5+) realtor 12 real estate other traumatic event, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Pages 1 and 2 should be George E. Lashley, Jr. Ruth Irene Boden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Roger D. Compton - son 543 Barksdale Lane, Hedgesville, W. Va. 25427 Baltimore, 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any injury or once. ^ 4 □ Donation 5 □ Other (Specify) Hagerstown Crematory 2/12/04 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kectal **Physician** Metastali disease or condition resulting in death) /Medical Examiner CACEH 451 A if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1☐Live birth 2 Fetal death 3 Ectopic pregnancy igned by the atte Month Day Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 No o 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1□ Yes 2 No 2 No 1 🔲 Yes of Vital or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 Yes 2 No 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 2 Accident Injury 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral [ To the Hospital to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 146561 24-2 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 1190 ROAD HARBUTOWN MI mr 21740. 31. Date filed (Month 32. Registrar's Signature State Registrar

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ST	OPHER A.	COURTER  For State Registrar	State of	of Maryland / Depa <i>Cer</i>	artment of I rtificate of		¶ental Hygi R•	ene g. No. 2004	065	jl
	Physician /Medical	1. Decedent's Name (First, Mide Christopher		er			2. Date of Death Month FEB	12, 2004 <sup>ear</sup>	3. Time of D	eat P
	Examiner	4a. Facility Name (If not institution 5455 BROOMES		1 702		or Location of Death REPUBLIC		4c. County of Death CALVERT		
ľ	Funeral Director	5. Social Security Number 213 78 3632	6. Sex 1☐M 2☐ F	7. Age (In yrs. last birthday) 42	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct 11	Year) Coun	lace (State or i try) ingto:	
	2	Usual Residence of Decedent								

rthan "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at hours after

if Health and Mental Hygiene. item 27 Is marked other than other traumatic event, I' = Me permit. Pages to Department of Hamportant: If ite any injury or ot once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

physician and the burial-transit certificate be executed as the attending | esn ò signed by the a been sig page certificate After death. Director: hours after 10 filled within 24 hours a Hospitel To the

Division of Vital Records, P.O. Box 68760,

eian. DC 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Calvert Port Republic 1 Tyes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5455 Broomes Island Road 20676 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ Xo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify: white Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) health care nurse 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Brian Thomas Courter Juanita Harbin ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita M. Harris - mother 8136 Zept Dr. King George VA 22485

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

1 Donation 5 Other (Specify)

A Donation 5 Other (Specify)

Netropolitan Funeral Service 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rausch Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition WITH ETHANOLISM a CHRONIC COMPLICATION ? resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. if yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☒Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be aminer' examiner? XXYes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 SNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier FEB. 13, 2004 O.C.M.E

DHMH 17 Rev 1/2001

State

Registrar

5

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 1 8 2004

31. Date filed (Month, Day, Year)

RUBIO, MD

32. Registres Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2004 Feb NWOOD raia 11:55 AM /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Talbot The Pines Genesis ElderCare Easton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 102 M 2□ F 204-40-261 Director Was Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State rthan "naturel", or Iteme 23s or 28s-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 DNo Completed by Funeral Director Rappe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 487 12. Was Decedent Ever in U.S.
Armed Forces? Roa 16 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes 212No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Black 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ges 1 and 2 should be filed within 72 it of Heelth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chain Associate 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mildred Rai ဥ inwood Lee Wells 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CRT, S: CK/ERV: 1/e N. J. 0808/ 1016-Hartley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ò Department of Importent: If any injury or once. Parudise Cemetery 2/10/04 Trappe, Maryland 4 Donation 5 Other (Specify) 22. Name and Address & Facility

HENRY FUNERAL Home, P. A.

510 Washington St. Cambr. dge, MD. 21613

Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between 21. Signature of Funeral Service Licensee 23a. Part / Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician whre cerebre /Medical Due to (or as a consequence of): Examiner exeprovesculor Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 11 10 ow is ceneral ue to (or as a consequence of): Box 68760. Physician/Medical ettending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Wes decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ₹ 2 1 Yes 2 No 3 Probably 4 Unknown meumon Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 Ø No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient ို 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Geath filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation Injury death. 2 □ No 2 ☐ Accident 1 Tes Director: 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours after To the Funerel Dire 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

DIEMIN

VENUE

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G

MD

200 /32. Recitrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200406543 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Helen Virginia Divelbiss February 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 219-10-5566 85 Director 1918 West Virginia April 18, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fehow ust be notified at 1 X Yes 2 No Directo Washington Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1082 Marshall Street 21740 or items 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced natural Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) then Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. ant: if item 27 Is marked other ther 12 0 Homemaker her own 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alonzo Shepherd Anna Mae Carter 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Hoover 8729 Sharpsburg Pike, Fairplay, Maryland 21733 daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot ange. 1XXeurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park 2/17/04 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home tred Li Vistas 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 40 CARDIA **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner EUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physicien Physician/Medical as attending for use as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the st 9 Unknown 9 Unknown ρ det signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 2 🗆 No 3 ☐ Probably 4 ☑ Onknown 1 Tyes peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate FIRM 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) <u>1</u> 1 In patient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation within 24 hours arter control to the Funeral Director: After a control to the Funeral Director of the funeral filled in by the funeral filled in funeral filled in funeral filled in fun 1 TYes 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29b. Signature and title of certifier 29c. License number 0

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

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Division of Vital Records,

DHMH 17 Rev 1/2001

19286

Begistrar's Signature

KRMEW VIEW OR HACKERSTOWN

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)

		1	For State Registrar	State of Maryland	/ Depa	rtment of tificate o	Health and of Death	Mental Hy	giene 2004	06544
ı	Physicia		1. Decedent's Name (First, Middle, Last)	DORSEY				2. Date of Dea	Day Year	3. Time of Death
	/Medic Examin	al -	4a. Facility Name (If not institution, give st	7		A	n, or Location of Dea		4c. County of Deeth	La cardana
			Anne Arundel Me 5. Social Security Number 6. Sex	7. Age (In yrs. la	r st birthday)	if Under 1 Ye			h Year) 9. Birthp	ace (State or Foreign
ŀ.	Funeral Director		216-28-0605 1A	M 20F 69	Yrs.	Months Da	ys Hours Mi	(Month, Da	-34 Mary	-
	ryland how		10a. State 10b. County		Town or Lo				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	n 72 hours after death with the Maryland "netural", or Itams 23a or 28e-f ehow voical Exeminat mars be notified at	Directo	10e. Street and Number	ARGUNEC	MUMA	101. Zip Coo	le		10g. Citizen of What Coun	
	th with 23a or mat be	rai Di	626 Wye Island			7007 344	401		USA 14. Race - Americ	on Indian
_	ter dea	Funeral	11. Marital Status  1 □ Never Married 2 Married	<ol> <li>Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes 2 ② 文</li> </ol>	1	Yes, specify (	of Hispanic Origin? Cuban, Mexican, Pue	Specity Yes or No erto Rican, etc.)	Black, White,	
500	nours al ural', or	by	3 ☐ Widowed 4 ☐ Divorced	/ `			Specify: BLA	dustry		
- - - - -	- 32	piete	3 Widowed 4 Drorced   If Yes, Give   1 Yes 2 A No Specify:   1 Yes 2 A No Spec							ŕ
.4	nd 2 should be fill alth and Mental H 27 le marked out r traumatic even		12th  17. Father's Name (First, Middle, Last)	0	T	ruck D		ame (First, Middle,	City Of Ar	napolis
and		To Be	John B. Dorsey	sr.				Ly Parke		
Mary			19a. Informant's Name/Relationship (Typ		19b. Mailir				er, City or Town, State, Zip	
	Hea Hear err		Jean V. Dorsey ( 20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of natory or other	f	_Annapol Date	15 Md 21 20c. Location - City or To	
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Ball	permit Depart Impor any in		21. Signature of Funeral Service License	en M00485	. W	m. Ree	ddress of Facility SE & SOI	ns Mortu	ary, P.A. s, Md. 2140	)1
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Vital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?		/			Death (Check only		
of V	hys this al dii	2	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury	ER/Outpatie		Injury at		idence 6 Other (Special how injury occurred	(y)
ion	Attending Physician: r death. ector: After this certified by the funeral director;	ation	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yeer)	Injury	М	Work? 1 ☐ Yes 2 ☐ No			
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factory, or	fice	28f. Location ( City or To	(Street and Number or Rur wn, State)	al Houte Number,
_	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	dical C	29a. Certifier 1 Certifying Physic (Check only and)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deal tion and/or in	th occurred at to	he time, date and pl my opinion, death o	ace, and due to the courred at the time	cause(s) and manner as s date and place, and due t	itated. o the cause(s)
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			30. Name and address of person who co	mpleted cause of death (Item  ### ### ### ### ####################	(23a) (Type	Print)	A STE	211 AM	02/13/0 WAPOLIS MU	21401
	Si Regis	tate trar	31. Date filed (Month, Day, Year)	32. Resistrar's Signa	ture	frank)				

State of Maryland / Department of Health and Mental Hygiene 2001 06545 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 0950 AM 20 2004 Paul Walter Eldreth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Cecil Elkton Union Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1XM 2□F Yrs. June 17, 1922 North Carolina 81 **Director** 242-28-1958 Usual Residence of Decedent within 72 hours after death with the Maryland 10d Inside City Limits 10c, City, Town or Location 10a. State 10b County r than "netural", or items 23e or 28a-f show the Medical Exandix rimust be notified at 1 ☐ Yes 2 ☑ No Director Elkton Maryland Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21921 55 Walnut Grove Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Machine Operator Paper Manufacturing 10 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental H permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 ia marked any injury or other traumatic ev Ellen Eldreth John Eldreth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Alda Drive, Elkton, Maryland 21921 Ted Eldreth/Son 20b. Place of Disposition (Name of cemetery, cramatory or other place)
Cherry Hill
Methodist Cemetery 20c. Location - City or Town, State 20a. Method of Disposition February 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) 24, 2004 Cherry Hill, Maryland 22. Name and Address of Facility
Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee ules) H 1103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

The condition

The condition

The condition of t Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Embousm **Physician** hours /Medical Due to (or as a consequence of) Examiner Deep Vein Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of) ba axe physician Physician/Medical the certificate as attending 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year ō 4☐Pregnant at time of death 5 Other (specify) ed by the a detached for 1 ☐ Yes 2 ☐ No 9 Unknown requires that signed a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Cardiomyopath schemic 1 🗌 Yes No 3 Probably 4 □Unknown been signal Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy certificate 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2**XI**No 1 patient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes this After thi 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide ö Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier S. Lu 0058354 DIMO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLONIAL Way 101 MD Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 2 2004 Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Box 68760

o

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06546 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb. 2004 **Physician** 8:40 a M Ernest Clark EICHELBERGER /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Ravenwood Lutheran Village Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 18, Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 17 M 2□F 83 220-05-6721 1920 Maryland Director Usual Residence of Decedent ss 1 end 2 should be filled within 72 hours effer death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28e-f ahow other treumatic event, the Maddral Examinat must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1X Yes 2 No Hagerstown **Funeral Director** Washington Maryland | 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 U.S.A. 21 E. Baltimore Street 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1∑Yes 2 □ No If Yes, Give Year or Dates:1942-45 1 ☐ Never Married 2 ☐ Married 21215-0036 1☐ Yes 2√√2 No Specify: Specify: White Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Restaurant 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Mary Edith Clark Raymond Foster Eichelberger ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 593, Olney, Maryland 20830 Nelson L. Eichelberger- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of Hi
Importent: If Itel
any Injury or oth 1 XBurial 2 Cremation 3 Removal from State Hagerstown, Maryland Rest Haven Cemetery | 2/10/04 4 ☐Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Minnich Funeral Home 21. Signature of Eunerel Service License 45 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onser and Death Immediate Cause (Final disease or condition resulting in death) Enysician U Come /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Physician/Medical Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, to Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: V Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No 2 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification; 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature D0056783 2004 SMA completed cause of death (Item 23a) (Type, Print) nd add Medical Campus Dr., Hagerstown, Maryland 21742 Jeffrey 1(1110) urwitz, 32. Aggistrar's Signature ourse Registrar DHMH 17 Rev 1/2001

			For Stata Ragistrar	State of Maryland	/ Depa		ealth and M	lental Hyd	•	
	Physici		1. Decedent's Name (First, Middle, Last) Thelma Esteline H					2. Date of Dea Month Februar	th Day Ye y 13, 200	3. Time of Death 94 3:40 a. M
	/Medic Examin		4a. Facility Name (If not institution, give s Beverly Health Ca				Location of Death		4c. County of D	
	Funeral Director		5. Social Security Number 6. Sec		birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 25	( Year) 9.	Birthplace (State or Foreign Country) Maryland
pocha	3	_	Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Lo	ecation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
the the M.	or 28a-f	by Funeral Director	Maryland Washing		Smitl	10f. Zip Code		1	log. Citizen of What	
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1215-0036	ral', or iten	by Fun	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 □Yes 2 ☒ No If Yes, Give Year or Dates:	1	If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, V	white, etc.
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Aary	and M		19a. Informant's Name/Relationship (Ty						r, City or Town, Stat	
re, l	thealth item 27 other t		Carolyn M. Heiks  20a. Method of Disposition	20b. Plac		SCOUTIET A sition (Name of matory or other place			, Marylan 20c. Location - City	
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H	,6		30. Name and address of person who co		Ba) (Type,		_	10		,
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  FARI) MURSHED 1/24 Opal Ct. Hagerstown M  State Registrar  81. Date filed (Month, Day, Year)  12. Pegistrar's Signature							7 / /		

			1 - For State Registrar	State of Maryl	and / Dep	artment of I	Health and M Death	Mental Hygie		4 06548
(td	Dhusisi		1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
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			Anne Arundel Medi			Annar	olis If Under 24 Hrs.		Anne Ar	
	Funeral		5. Social Security Number 6. S	□M 2 <b>□</b> F	rs. last birthday) Yrs.	Months Days		8. Date of Birth (Month, Day, Ye		rthplace (State or Foreign country)
н	Director		210-30-1469 Usual Residence of Decedent	7	4			July 8,	1929   A	ustria
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Exartinar must be rocitised at		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	be filed within 72 hours after death with the Marylan stal Hygiene. ed other than "natural", or items 23a or 28a-f ehow event, the Medical Exercities must be rotified at	ţò	Maryland Anne A	rundel	Annapo	lic				1@ Yes 2 □ No
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ထ္	or It	正	1 ☐ Never Married 2 ☐ Married	1 Tes 2 No		1 ☐ Yes 2 No		nican, etc.)	Black, Whi	te, etc.
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Maryland	should be nd Menta i marked umatic ev	<u>-</u>	Norbert Poschle 19a. Informant's Name/Relationship		19b. Maili	na Address (Street		unknown) al Route Number, Cit	v or Town State	Zin Codel
Ž	permit. Pages 1 and 2 should Department of Health and Man Importent: If Item 27 is marke any injury or other traumatic 00cs.		_Paul Fink/ son					Tampa, FI		Lip 0000)
re,	s 1 au f Hea item othe		20a. Method of Disposition	1	b. Place of Dispo	osition (Name of	1		Location - City or	Town, State
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	e Ho 124 h	Medical	(Check only 2 Medical Exam	iner: On the basis of examinand manner stated.	ination and/or inv	estigation, in my o	pinion, death occurre	ed at the time, date a	nd place, and due	to the cause(s)
	withir To th comp	M	29b. Signature and title of certifier			29c. Licens	e number	29d. D	ate signed (Monti	n, Day, Year)
•			1 Dans	voen	- Mr	D	16964	2 -	16-04	
		1	30. Name and address of person who o	ompleted cause of death (li	lem 23a) (Type, i	Print)				
			James Chaco	150	9 R,	the	Huy	Arus	2 mr	21012
	Sta		31. Date filed (Month, Day, Year)	32. Refistrar's Sig	nature	1				

ysicia		1 - State Registrar Unipend ITem#2		29,3/12/0	щеа	te of L	Jeatn	2. Date of			<ul> <li>→ 065</li> <li>3. Time of Deat</li> </ul>
ledic		Sheila A, Fer	m					Januar	Day 26.	2004	11:31 A
amin		4a. Facility Name (If not institution, give s	street and number)		4b. Cit	y, Town, or	Location of De			County of Deat	h
•	- 4	32 North Bluff				esape	ake Ci			Cecil	
eral ctor		5. Social Security Number 6. Sex 221-46-6686	2 XX 37	s. last birthday) Yrs.		Days		lin. 8. Date of (Month,	Birth Dey, Year) 30 - 196	66 Wil	hplace (State or Forduntry) mington, D
뉳		10a. State 10b. County		City, Town or Lo							10d. Inside City Lin
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800	Oire	10e. Street and Number			10f. Z	ip Code				en of What Co	•
Tan I	la	32 North Bluff Ro			21915	_	10 11 11		ted Sta		
Dec	Funeral Director	11. Marital Status  1 Never Married Married	U.S. 13.	was Dec If Yes, sp	edent of His ecify Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or lerto Rican, etc.)	No-	4. Race - Ame Black, White		
9	by	3 Widowed 4 Divorced	1 ☐ Yes 2 XXIIIO If Yes, Give Year or Dates:		1 🗌 Yes	27CM0	Specify:			Specify: Wh	ite
ical i	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Us	ual Occupa	ition	working	16b. Kin	d of Business/I	Industry
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		Jimmy R. Atkinson						e Boyer	Jie, Maluell S	ourname)	
		19a. Informant's Name/Relationship (Ty)		19b. Mailir	ng Addre	ss (Street a	•	Rural Route Nu	n <i>ber, Cit</i> v or	Town, State. Z	ip Code)
Tran I		John S. Ferm/Husba									yland 219
y or othe	1	20a. Method of Disposition  ↑ Surial 2 □ Cremation 3 □ R  1 □ Donation 5 □ Other (Specify)	lemoval from State gr	Place of Dispo cemetery, crer ace Lawn	sition (N natory or mem	ame of other place IOTIAL	Jan	Date uary 30,		ation - City or Will	Town, State mington,
in in	ľ	21. Signature of Furget Server Lice		park 22	2. Name	and Addres	s of Facility (	crouch F	ineral	Home De	laware
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res that the death certificate be executed res that the death certificate be executed  Ex  Ex  Ex  Ex  Ex  Ex  Ex  Ex  Ex  E		Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last	Due to (or as a consi								
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 SUnknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic Other	pregnancy specify)			2	3d. Date of delin	very Day Year
ep eq	by	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying	cause give	n in Part I.		_		the cause of death
the set the digner of the dign								21,32	Yes 2		obably 4 QUnkno
hould	Completed							pe	topsy formed?	24b. Were aut prior to c death? 1 X Yes	topsy findings avail- completion of cause 2 No
page 2	Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2			Othe		Death (Check on			74
page 2	0	27. Manner of Death  1 X Natural 5 Pending	28b. Time of Injury		28c. Injury Work	at ?	-,	e how injury		ify) At sce	
al director, page 2	Ion: T	2 ☐ Accident investigation	home, farm, str	M eet, facto		′es 2 □No		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
in by the funeral director, page 2	ertification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Spe		death occurred at the time, date and place, and due to the or investigation, in my opinion, death occurred at the time.			ue to the cause(s) and manner as stated.			
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illed in by the funeral director, page 2	ertification:	3 Suicide 4 Homicide  6 Could not be determined  29a. Certifier (Check only AMedical Examir	sician: To the best of my k	nowledge, death	vestigatio	on, in my op 9c. License	inion, death or	ccurred at the tim	e, date and p	place, and due	to the cause(s)
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	Physici /Medic	cal	Decedent's Name (First, Middle, Last)     HTLDA PEARL GR      4a. Facility Name (If not institution, give s	OSS treet and number)	4b. City, Town, or Location of Death	2. Date of Death Month February	Day Year
	Examir Funeral Director	ier	REEDERS MEMORIAL H 5. Social Security Number 6. Sex	OME	BOONSBORO If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, SEPT. 16	WASHINGTON  9. Birthplace (State or Foreign Country)
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Markical Exampliant or other traumatic event, the Markical Exampliant.	ai Director	Usual Residence of Decedent	TON			10d. Inside City Limits 12€ Yes 2 □ No g. Citizen of What Country? U.S.A.
9003	nours after deal ural', or Items :	d by Funeral	1 ☐ Never Married 2 ☐ Married 3 ፟፟፟	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHTTE
121215-0036	filed within 72 h Hygiene, ther then "natu ent, the wester	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 8	(Give	Jent's Usual Occupation kind of work done during most of work DO NOT use retired) HOMEMAKER	ing	6b. Kind of Business/Industry  OWN HOME
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, Ite M.	To Be	17. Father's Name (First, Middle, Last)  DONOVAN CHARLES SM.  19a. Informant's Name/Relationship (Ty)		MARTHA E	ELEN LAP	OLE
Baltimore, Ma	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra QDCB.		SHIRLEY A. BRASHEAR  20a. Method of Disposition  1 Regurial 2 Cremation 3 Regurial 2 Chemistry  1 Donation 5 Other (Specify)  21. Signature of June 2 Service Licenses	emoval from State  20b. Place of Dispo cemetery, crei BOONSBOR	O CEMETERY 2/13, Name and Address of Facility ST FINERAL HOME	Vate 20 V2004 <u>F</u> V606 Old	illiamsport, MD 21795 C. Location · City or Town, State  BOONSBORO, MARYLAND National Pike D, Maryland 21713
	Physician /Medical Examiner		23a. art1. Enter the dise so complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not ent e cause on each line.  Due to (or as a consequence of):	the state of the s		and the same of th
3760,	le be executed ysician and e burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):			
P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Records, P	requires that sen signed b tould be deta	ted by Pl	•	tributing to death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
	an: The law ifficate has b or, page 2 sl	e Completed by	25. Was case referred to medical		26 Place of Death	24a. Was an autopsy performe	ŽNo 1 ☐ Yes 2 ☐ No
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation; To B	avaminar?	ospital: 1 Inpatient 2 ER/Outpatier  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	t 3 DOA Other: 4 Nursing Ho	, , , , ,	ce 6 □Other (Specify)
Divis	pital or Atte	I Certification;	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	<u> </u>	City or Town,	, , , , , , , , , , , , , , , , , , ,
	o the Hos	Medical	(Check only one)  2 Medicel Examir  29b. Signature and title of certifier	icien: To the best of my knowledge, deather: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)  d. Date signed (Month, Day, Year)
)			30. Name and address of person who co	mpleted cause of death (Item 23a) (Type,	D32518		2.10.04
7	Sta	ate		+ 21 Wyand Drive K	eedvs ville .Marylar	d 21756	301-432-2222
	Regist		, rn T T 70	U4 Same D. D.	rested		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Year Kenneth W. Grooms Feb. 11, 2004 10:50 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mariner of North Arundel Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sav 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days 1**⋈**M 2□ F Director 214-72-0144 46 1957 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow is marked other than "natural", or Itams 23a or 28a-f ehov eumatic event. The Medical Exeminar mast be notified at MD 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 King George Drive 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. within 72 hours after 1 XNever Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Marvin Grooms Elsie (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health ar
Important: if Item 27 is
any injury or other treu James P. McDermott/Friend 3807 Mayberry Avenue Baltimore, MD 21206 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 14, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Glen Burnie, MD 21. Signature of Fundal Strvice Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician arcinoma month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed as the burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physiclan/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No o. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? (es 2500 certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 2 1 Inpatient 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA within 24 hours after upge...
To the Funerel Director: After thir 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title certifier 29c. License number 29d. Date signed (Month, Day, Year) February 12, 2004 325 HOSPITAL DRIVE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAWHNCY MD GURMEET CLEN BURNIE, MD 21061 31. Date filed (Month, Day, Year) FEB 17 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2016 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Elston Franklin Hess, Sr. Febuary 2004 11 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington County Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 66 Director 215-34-4086 Sept. 15, 1937 West Virginia Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehow the Medical Examinat must be notified at 1 Yes 2 □ No Director Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Avalon Avenue Funerai U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Item any injury or other traumatic event, the Medical Exercises once. Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking Company 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ( Elston Edward Hess Isabelle Virginia Medler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Elena Hess/Wife 7 Avalon Ave. Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 

Burial 2 □ Cremation 3 □ Removal from State

Output

Outp Cedar Lawn Mem. Park Feb. 14, 2004 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, Maryland Munior N-XIMI 23a. Part1. Enter the Asease, or complications hat cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPO MARY **Physician** ARTERY DISEASE disease or condition resulting in death) /Medical Examiner MELLITUS DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) signed by the a ☐ Yes 2☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. id tobacco use contribute to the cause of death? REMAL FAILURE 2 🗆 No 3 Probably 4 Unknown peeu MYELDMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform CHRONIC OBSTRUCTIVE certificate DISEASE 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 300 Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death funeral 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After t 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) D60764 smarie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) "OAK HILL AVE, HAGERSTOWN, MD 21742 MD 129 BRANISLAV -O MANIC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			Please	ype or Print in					_	<b>).</b>
			For State	State of Maryla				Mental Hyg	giene and	1 00000
			1 - State Registrar		Cei	tificate of	Death		10g, No. 200	
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea _Month	ith Day Yea	3. Time of Death
	/Medi		William Doug		el			Febry	7 200	
	Examir	ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Dea	ath 0	4c. County of D	eeth
			Washington County			Hagers			Washingt	on County
и.	Funeral		5. Social Security Number 6. Se	X 7. Age (In y	rs. last birthday) 76 Yrs.	If Under 1 Year Months Days	Hours Min	n. (Month, Day	, Year) 9.	Birthplece (State or Foreign Country)
	Director		220-18-0618 Usuel Residence of Decedent		70			June 6	1927 M	aryland
	/land		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Man Fr sh	tor	Maryland Washingt	on.	Hagerst	own				1 ☐ Yes 2 No
	or 28g	Director	10e. Street and Number	.1		10f. Zip Code			10g. Citizen of What	Country?
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Exaciner must be multified at		13334 Keener Road			21742	2		U.S.A.	
	dea r dea	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13. \	Was Decedent of H	lispanic Origin? (	Specify Yes or No- erto Rican, etc.)	14. Race - A Black, W	merican Indian,
36	or it	y F.	1 Never Married 2 Married	Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give		Yes 2 No	Specity:	1 311/	Specify: W	
00	ural	Completed by	3X Widowed 4 □ Divorced	Year or Dates:	100					
5	n 72	lete	15. Decedent's Ed (Specify only highest grad	le completed)	(Give	ient's Usual Occup kind of work done DO NOT use retired	during most of w	orking	16b. Kind of Busine	ss/Industry
112	filed within Hygiene.	шc	Elementary/Secondary (0-12) unknown	College (1-4or 5+)		Salesn	-,		The volet n	g Company
0	Hygid Hygid Sther	BeC	17. Father's Name (First, Middle, Last)			batesi		ame (First, Middle,		g Company
lan	Mental Mental arked o	To B	Claude Oscar Hotte	.1			Ne1	lie Marga	ret Hamme	rs
Maryland 21215-0036	2 should and Men 18 marks sumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	g Address (Street			r, City or Town, State	
	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Marical Examiner interior or or other traumatic event, the Marical Examiner interiors.		Donna Palkovitz/	Step-daughte	r 1950	8 Marsh (	Circle H	agerstown	, Marylan	d 21742
or c	of He fitter		20a. Method of Disposition	1	. Place of Dispo cemetery, cren	sition (Name of natory or other place	ce)	Date	20c. Location - City	or Town, Stete
Ĕ	nit. Pages artment of l ortant: If Its injury or o		1 ☐ Burial 2X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		mithsbu	rg Cremat	ory Feb	.10,2004	Smithsbur	g, Maryland
Baltimore,	permit. Pag Department Important: I eny injury c		21. Signature of Funeral Service Licens	:00				_	-	neral Home
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F			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused the de ne cause on each line.	eath. Do not enti	er the mode of dyin	ng, such as cardi	ac or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Atheroscle	rotic	Ordio	vascul	ar Disec	25€	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons						
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89	eath certificate attending phy: for use as the	ledi			=5					
Вох	h cer endir r use	an/N	23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy	,		23d. Date of	delivery
	deal ne att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (specify)			Month	Day Year
P.0	that the de ned by the a detached to	Physician/Medic	9 Unknown							
Ś	igned be d	by	Part II. Other significant conditions co	ntributing to death but not r	resulting in the ur	nderlying cause giv	en in Part I.		✓	to the cause of death?
ord	w requir been si should	ted	Hypertensie	<i>11</i>				1 🗆 Ye	s 2/21No 3□	Probably 4 Dunknown
lec	e law has b	Completed	Hyperlipider	nia				24a. Was a autops	y prior t	autopsy findings available of completion of cause of
al F		S	,					perform 1 ☐ Yes		es 2 No
of Vital Records,	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Y	Oth	00	ath (Check only on		
of		. To	1 ☐ Yes 2 No 27. Magner of Death	28a. Date of Injury	ER/Outpatien	3LI DUA	4 U Nursing		once 6 Other (S)	Decify)
	ding h. h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injun Worl	k? Yes 2 □ No	200. Describe in	ow injury occurred	
Division	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - Al	t home, farm, stre			28f. Location (St	reet and Number or	Rural Route Number,
	al or A s after il Direction by	Certification:	4  Homicide determined	building, etc. (Spe	cify)			City or Town	n, State)	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier Certifying Phy	sician: To the best of my k	nowledge, death	occurred at the tin	ne, date and place	e, and due to the ca	ause(s) and manner	as stated.
	the H in 24 the F iplete	ledical	one)	inar: On the basis of exami and manner stated.	ation and/or inv			curred at the time, d	ate and place, and d	ue to the cause(s)
		Σ	29b. Signature and fittle of certifier	// /	1 2 1	29c. Licenso	e number	2	9d. Date signed (Mo	nth, Day, Year)
7	ioth		Marge (1	Runa p.	M.V.H.C	D-1	13 41		eb. 9,2	2004
H	10+1		30. Name and address of person who d							
		10	George Newman 111	10 Medical C	ampus Ro	1. Hagers	town, Ma	ryland 21	742	
	Sta Registr		31. Date filed (Month, Oay, Year) FEB 12 2	304 Som	1. A.	and the				

			1 - For State Registrar	State of Ma	ryland	/ Depa		t of H	ealth a			ene	2004	00001
			Registrar  1. Decedent's Name (First, Middle, La	st)		Cei	runcate	OIL	Jean		. Date of Death	)		3. Time of Death
	Physici /Medio		John Ho	obar, Jr.						$\mathbf{F}$	ebruary	7 17,	$20^{\circ ear}$	7:35 P M
}	Examin		4a. Facility Name (If not institution, giv				4b. City, 1	Town, or	Location of	of Death			ounty of Deat	
			13195 Woodbank I		4		Lus		W. Harday C	0411		1	alver	
	Funeral Director		5. Social Security Number 6. S 210–09–7928	Sex 7.Age IQXM 2□F	(In yrs. last	Vrs.	If Under Months	Days	If Under 2 Hours	Min. M	. Date of Birth (Month, Day, arch 1(	Year)	9. Birt Co 22 Pet	hplace (State or Foreign untry) nnsylvania
			Usual Residence of Decedent									,, ,,	24 101	and y I varita
	anylan show	_	10a. State 10b. County  MD Calve		10c. City, T	_	ocation							10d. Inside City Limits 1 ☐ Yes 2X No
	28a-f	Director	MD Calve	ar c	ьu	sby	10f. Zip	0-1-				0.11	of What Co	
	within 72 hours after death with the Maryland ene. ene. ten. "natural", or items 23a or 28a-f show te M. Jical Exacitrer i. ust be inclified at	- Di	13195 Woodbank I	Road				2065	7			_	ed Sta	•
	death	nera	11. Marital Status	12. Was Decedent Ev Amed Forces?	ver in U.S.	13.	Was Decede	ent of His	spanic Orig	gin? (Specif	ly Yes or No- can, etc.)		Rece - Ame	rican Indian,
98	or ite	y Fu	1 ☐ Never Married 2 Married	1 X Yes 2 ☐ No If Yes, Give	WWI.	<b>T</b>	1 ☐ Yes 2		Specify:	, rusito nit	zan, etc.)	Sp	Black, White ec <i>ify:</i> V	white
Š	hours tural',	q pa	3 Widowed 4 Divorced	Year or Dates:	1 1	6a Dece	dent's Usual	l Occupa	tion				of Business/	Industry
5	in 72	e Completed by Funeral	(Specify only highest gra	ade completed)		(Give	kind of worl DO NOT use	k done d e retired)	uring most	of working		DD. KING	or business/	industry
212	d with giene er the	Com	Elementary/Secondary (0-12)	College (1-4or 5+	7	Super	rvisor	5			C	&P T	'elepho	one Co.
<u>n</u>	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, Last	)							First, Middle, M	<i>laiden S</i> u	mame)	
Maryland 21215-0036	nould d Men narke natic	<sup>2</sup>	John Hobar  19a. Informant's Name/Relationship (	Time Print		Oh Mailie		(Ctront o	<del>-</del>	y Evi		C2T	0444- 7	En Code
Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Branicatic structure of the recommendation of the Maryland Examination to the notified at 200c.		Rose K. Hobar	(WIFE)							Route Number, usby, M			
Baltimore,	Pages 1 and of He out: It item		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐				sition (Nam matory or oti			Date			ion - City or	
<u>=</u>	iit. Pa artmen artent: njury		<ul> <li>4 □ Donation 5 □ Other (Specif</li> <li>21. Signature of Funeral Service Licer</li> </ul>	1-1	Metr						18,2004 ch Fune			
Ba	Dep Impo		1	It MO	1095	- 4	405 Bı	room	es Is	land :	Rd. Por	t Re		c, MD 20676
			23a. Part1/Enter the disease, or comshook, or heart failure, 1 st only	plications that caused to	he death. D	o not ent	er the mode	of dying	, such as c	cardiac or re	espiratory arre	st,		Approximate Interval Between
Ç	Physician		Immediate Cause (Final disease or condition	CARC			COL							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequen									
		er	Sequentially list conditions if any, leading to immediate	b. Due to (or as a	consequen	ce of):	7.5							
	ate be executed hysician and he burial-transit	Examiner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c										
760,	te be executed ysician and le burial-transit		resulting in death) Last	Due to (or as a	consequen	ce of):								
	icate by physic s the bu	dical		d										
89 X	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome of	f pregnancy							224	Date of deli	
.O. Box	death certifica e attending ph id for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 4 Pregnant at ti	Fetal dea	ath 3 □	Ectopic pre Other (spe					230	. Date of deliment	Day Year
Ŏ.	at the de by the a tached	hys	9 Unknown	9□ Unknown										
s, G	es thal igned t be det		Part II. Other significant conditions of			g in the ui	nderlying ca	use give	n in Part I.					the cause of death?
ord	w require been sign should b	ted	PNEVMONIA,	HTN, DI	Υ\					_	1 <del>L Y</del> es	2 □ N	lo 3∐Pro	obably 4 □Unknown
Sec	e la has	Completed by									24a. Was an autopsy perform			topsy findings available ompletion of cause of
E E	ilcian: The l certificate ha rector, page		25. Was case referred to medical								1 ☐ Yes 2	2No	1 🗆 Yes	2 No
5	ysician: nis certifica director, p	o Be	examiner?  1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \)	Hospital: 1 ☐ Inpatient	2 ∏ ER/	Outpatien	it 3 DOA	Othe			Check only one 5 Resider		Other (Spec	ufu)
0	ding Phy h. After thi funeral o	T :uc	27. Manner of Death 1 Statural 5 ☐ Pending	28a. Date of Injury (Month, Day)	281	o. Time of		lc. Injury Work		-	. Describe hov			
Sior	Attending ir death. ector: Atter by the fune	catic	2 Accident investigation	n		,=.,	M		es 2□N	10				
Division of Vital Records,	in Life	Certification;	3 Suicide 6 Could not b		y - At home, (Specify)	, farm, str	eet, factory,	office		28f.	Location (Stre City or Town,	et and N State)	umber or Rui	ral Route Number,
_	e Hospital or 24 hours afte Funerel Dir etely filled in		29a. Certifier 1 ☐ Certifying Ph	ysicien: To the best of	my knowled	dge, death	occurred a	t the time	e, date and	f place, and	I due to the cau	ise(s) and	manner as	stated.
	To the Hospital within 24 hours a To the Funerei I completely filled	edical	(Check only 2 Medicel Exar	miner: On the basis of e and manner state	xamination	and/or inv	vestigation, i	in my opi	inion, death	h occurred a	at the time, dat	e and pla	ce, and due	to the cause(s)
	To the within 2.	M	29b. Signature and title of certifier					License		3	29		gned (Month	
•				1	4 10			136	5960	7		reb.	. 18,	2004
11	)+1		30. Name and address of person who Scaria Mathe					n Rd	l. Lus	sby. M	ID 2065	7		
	Sta		31 Date filed (Month, Day, Year)	32 Registrat	Signature					-47	- 2000	-		
	Registr	ar	LEDI	8 2004	ALUS. 1	J.	Rose	W						

Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Per usual services of the service of the services of	Itimo It. Page Itment of Itment: If Itment: If Itment: If Itment: If		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)  21. Signation of Full wrall Service ⊿Cens	Maryl	and Veterans Cen.	2004	Crownsvill	le, MD
Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Per usual services of the service of the services of	Baltimore, Maryle permit Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marks any injury or other traumatic once.		* 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of cemeter Maryl.	of Disposition (Name of iny, crematory or other place) and Veterans Cem.  22. Name and Address of Facility	2004 (	oc. Location - City or	le, MD
O that the design of the state	760, Physician   Physician and Examiner   Physician and ph	cai	21. Signature of Fullwral Service Incenses 23a. Part I Enter the disease, or complete shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Death or nour) that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a consequence  Due to (or as a consequence	22. Name and Address of Facility Barranco Sons, 495 Gov. Ritchie  not enter the mode of dying, such as care  (A of):  of):  3 Ectopic pregnancy	P.A. Sever Hwy. Sever	rna Park Frna Park,	Funeral Hon MD 21146  Approximate Interval Between Oasst and Death > 20 FARS  3 WEEKS
	ords, P.O. equires that the d en signed by the ould be detached	þ	9 ☐ Unknown  Part II. Other significant conditions con	9□ Unknown	n the underlying cause given in Part I.			
24a. Was an autopsy findings avaigned to be supported to medical examiner?  25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  27. Manner of Death  28. Date of Injury  28. Date of Inju		e Completed	V		0	autopsy performe 1 Yes 2	g? prior to death?	completion of cause of

		_	State of Maryland / Department	artment of Health and Mertificate of Death		ene No. 2004 06556				
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death				
	Physicia /Medic	_	William Otis Harvey		February	13,2004 1:40 p. M				
	Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deeth		4c. County of Death				
			1495 Velmeade Lane	Davidsonville	2 D / Dist	Anne Arundel				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 7. Age (In yrs. ast birthdey) 93 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign Country)				
	Director	}	577-03-5560 TX 93 Yrs.  Usual Residence of Decedent		June 15,	1910 Washington, DC.				
	/land		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits				
	Man,	ţ	Maryland Anne Arundel Davidsonv	ille		1 ☐ Yes 2 ☐ No				
	death with the Maryland ms 23e or 28a-f show	Funeral Directo	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?				
	23e c	ai	1495 Velmeade Lane	21035		nited States				
	r dea	ne l		Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.				
36	2 should be filed within 72 hours after death with the Marylan and Manhall Hygiene. and Manhall Hygiene is marked other then "natural", or fleems 23e or 28a-f show aumatic event, the Medical Examer recommendation of the Medical Examer recommendation.	by Fi	1 ☐ Never Married 2 反 Married 1 ☐ Yes 2 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🙀 No Specify:		Specify: White				
21215-0036	hour tural	ed t	15 Decedent's Education 16a Dece	dent's Usual Occupation	16	b. Kind of Business/Industry				
5	n "ns	pet	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)	g					
212	y with	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  6 Mecha	anic		Trucking				
פַ	e filed al Hygi other vent, I	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)				
Maryland	should be and Mental s marked o umatic eve	10	William Otis Harvey	Ida Blac						
a	s 1 and 2 should I Health and Mer Item 27 is marke other traumatic		1121	ng Address (Street and Number or Rural						
	s 1 and 3 of Health Item 27 other tr					Lie, Maryland 21035 c. Location - City or Town, State				
Ö	Pages 1 nent of H ent: If Iter ary or oth		cemetery, cre	matory or other place)						
Ē	tmen tent: njury			Cremation Cutr. Feb. 1		Chester, Maryland				
Baltimore,	permit. Pages Department of I Importent: If Its any injury or o once.			814 Bestgate Road A		cal & Memorial Care s, Maryland 214-1				
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arres	t, Approximate Interval Between Onset and Death				
Ų.	Physician		Immediate Cause (Final disease or condition CACHEX)	A -		Oliset and Death				
	/Medical		resulting in death)  Due to (or as a consequence of):	· · · · · · · · · · · · · · · · · · ·	4	0				
	Examiner		Sequentially list conditions b. CARDIO - VASCULAR JUSTA							
	ed isit	ine	Tainy, sading to immediate cause. Enter Underlying Cause (Disease or injury							
	xecut and al-trar	Examiner	that initiated events c							
8760,	ate be executed hysician and the burial-transit	icai E								
687	ficate g phy: as the	ed	u.							
Вох	death certifica e attending ph ad for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetel death 3 [	□Ectopic pregnancy		23d. Date of delivery				
Ď.	death e atte	icia		Other (specify)		Month Day Year				
P.O.	that the de led by the a detached f	hys	9 Unknown							
	res tha igned be de	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?				
ord	law requires that the as been signed by th 2 should be detache	ted			1 L Yes	2 Mo 3 ☐ Probably 4 ☐ Unknown				
Records,	elawr hasbe je 2sh	ple			24a. Was an autopsy	24b Were autopsy findings available prior to completion of cause of death?				
=	Thate page	Completed			performe	No 1 ☐ Yes 2 ☐ No				
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred medical examiner?  Hospital:	26. Place of Death Other: 4 Thursday Home	1					
ð	Phys this al dir	٠ <u>.</u>	1 Yes 2 No 1 Inpatient 2 ER/Outpatie  27. Manny Death 28a. Date of Injury 28b. Time of	ent 3 DOA 4 Nursing Hom	8d. Describe how	ce 6 Other (Specify)				
no	ding h. After fune	tlon	1 Matural 5 Pending (Month, Day Year) Injury	of 28c, Injury at 25 Work? M 1 ☐ Yes 2 ☐ No						
Division	Attending ir death. ector; Afte by the fune	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st	treet, factory, office 2	8f. Location (Stre	et and Number or Rural Route Number,				
Σ	after Dire	Certification;	4 Homicide determined building, etc. (Specify)		City or Town,	State)				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deal (Check only 2 ☐ Medicel Exeminer: On the basis of examination and/or in							
	the H in 24 the Fi	edical	one) and manner stated.							
	To To Com	Σ	29b. Signature and title of certifier	29c. License number		I. Date signed (Month, Day, Year)				
			- Cuesti	2000 30		ebruary 16, 2004				
			30. Name and address of person who completed cause of death (Item 23a) (Type	- 1	_	ince Frederick, D. 20678				
			Issam F. Damalouji, M.D. 135 West I  31. Date filed (Month, Day, Year)  32. Begistrar's Signature	Dares Beach Rd. Sui	te101 M	<b>₽.</b> 20070				
	Sta Regist		FEB 1 8 2004							

			For Stete Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F ertificate of		d Mental Hy	giene 2	004	0655
	Physici		Decedent's Name (First, Middle, L.  Robert	Maurice I	reland			2. Date of Do Month Februa	Day	Year 2004	3. Time of Death 1,45 pm
	/Medio Examir		4a. Fecility Name (If not institution, gi			4b. City, Town, o	or Location of D		-	nty of Death	· · · · · · · · · · · · · · · · · · ·
			11244 Vienna Dri	ve		Dent				roline	
П	Funeral			Sex 7. A 1 ☑ M 2 ☐ F	ge (In yrs. last birthday Yrs.	Months Days		Hrs. 8. Date of Bi Min. (Month, D.			lace (State or Foreign try)
	Director		220-28-0916 Usual Residence of Decedent	X	71 <sup>*\s.</sup>			October	5, 1932	Mary	yland
	land		10a. State 10b. County		10c. City, Town or L	ocation				11	0d. Inside City Limits
	Many a-fsh illied	io	Maryland Caroli	ne	Denton						1 ☐ Yes 2√∑ No
	in the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Coun	try?
	23e (23e (23e (23e (23e (23e (23e (23e (	10e. Street and Number  10f. Zip Code  11244 Vienna Drive  21629  11 Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (St					d Stat				
	tems	nuel	11. Marital Status	Armed Forces	? 1040	. Was Decedent of I If Yes, specify Cub	dispanic Origin an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)		ace - Americ lack, White,	
	be filed within 72 hours after death with the Maryland Hygione. ad other then "natural", or llems 23e or 28a-f show event, Ire Madical Evaninst must be retilled all	by F		1	140	1☐ Yes 2🙀 No	Specify:		Spec		•
3	thou cale	ed	3 □ Widowed 4 □ Divorced Year or Dates: 1969					Caucas Business/Inc			
3	nic and M	piet	3 □ Widowed 4 □ Divorced Year or Dates: 1969				working	Unite	ed Sta	tes	
21213-0030	d with giene er the	E O	11 HS Grad			lligence				Army	
2	al Hy d oth	Be (	17. Father's Name (First, Middle, Las	t)				Name (First, Middle		ame) —	
<u>y</u>	12 should be filed within h and Mental Hygiene. 7 is marked other than " traumatic evant, tre Mac	ျ	1102020 - 0	ter Irelan				ole Lee La		- 0 7:-	2:1-1
Mai yiand	12 sh hand 7 is no traum		19a. Informant's Name/Relationship Renate A. Irelan			•		r Rural Route Numb Denton, N			
	is 1 and 2 should of Health and Men itam 27 is marke other traumatic		20a. Method of Disposition	VIII C	- International	osition (Name of ematory or other pla		Date		n - City or To	
Dalilli IOLE,	Pages nent of h unt: If its ury or of		1 □ Surial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec			ematory or other pia Cemetery		19.2004	Dento	n, Mar	vland
		-	21. Sonature of Funeral Service Lice	-		22. Name and Addre	ess of Facility		Derico	ily ricit	y Laria
ă	permit. Departr Imports any inji		1 tandoble	floor		Moore Fun	eral Ho Second	me, P.A. Street, I	enton.	Maryl	and 21629
	Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	polications that cause y one cause on each	d the death. Do not er	nter the mode of dyi	ng, such as car	diac or respiratory	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):	<del></del>					
		er	Sequentially list conditions,	b. Due to (or a	s a consequence of):						
	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
<b>5</b>	cate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to (or a	s a consequence of):						
9700	ate be nysiciá he bui	dical		d							
	artifica ing pt e as tl	Med	IF FEMALE:								
7.0. BOX	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	у			Date of delive Month	ry Day Year
ב יפח	w requires that is been signed by should be detail	þ	Part II. Other significent conditions	contributing to death	but not resulting in the	underlying cause gr	ven in Part I.		tobacco use co <b>√</b> es 2□No		e cause of death? ably 4 ∐Unknown
n Records,	sicien: The law re certificate has bee irector, page 2 sho	Completed						24a. Wha auto perf 1 □ Yes		prior to con death?	osy findings available npletion of cause of 2 No
)   	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Ott		Death (Check only			
o vital	Phys this ral dir	۲.	1 ☐ Yes 2 ☐ No  27. Magner of Death	1 🗆 Inpat				ng Home 5 Res	how injury occ		")
	ding F	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of In (Month, D	ay Year) Injury	Wo	rk? ]Yes 2□No				
DIVISION	To the Hospital or Attending Physicien: The l within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not determine	be 28e. Place of Ir	njury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location City or To	Street and Nui wn, State)	mber or Rura	l Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 Medicel Ex-	Physicien: To the beseminer: On the basis and manners	t of my knowledge, dea of examination and/or stated.	ath occurred at the ti investigation, in my	ime, date and popinion, death o	lace, and due to the	cause(s) and date and place	manner as st e, and due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	7 DOD		29c. Licen	se number		29d. Date sign	ned (Month, I	Day, Year)
			- Call	a all	- and	L	352	84	2/13	3/04	2
			30. Name and address of person wh	completed cause of	death (Item 23a) (Type	S. Was	hingi	fon St	East	on m	109/201
		ate	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature				-111		
	Regist	rar	FFR 172	nna la	24	P . 3					

			riedse i	State of Marylan				•	ene ana	
			State Registrar			rtificate of L		Re	g. No. ZUUL	
100	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al .	William Rudolph JC  4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Death	Feb. 1	3 2004 4c. County of Death	9:40 p.m.
	Examin	er	Avalon Manor Nursi				stown		Washing	ton
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	nplace (State or Foreign untry)
1	Director		214-32-4862 Usual Residence of Decedent	M 2 F   69				Nov. 1 1	934 Mar	yland
	aryland show	_	10a. State 10b. County	10c. City	y, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 No
	the Ma	Director	Maryland Washingt	ton	Hager	stown 10f. Zip Code		10	og. Citizen of What Co	
	3a or		20526 Lehmans Mill	l Road			1742		U.S.A.	
	ame 2	iner		Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spi n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	rs afte	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☑ Yes 2 □ No if Yes, Give Year or Dates: Navy		1□Yes 2☒No			Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene diother than "natural", or itame 23a or 28a-f ehow event, the Medical Evantinal nitral be notified at	ted	15. Decedent's Educ (Specify only highest grade	ation	16a, Dece	dent's Usual Occupa	ation furing most of work	ina	16b. Kind of Business/I	Industry
121	ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired	)		Aluminum M	fo
d 2	Hygi Hygi Ifher nt, I	o Co	10 17. Father's Name (First, Middle, Last)	0	MTTI	wright	18. Mother's Name			ıg.
lan	should be fand Mental Is marked of	To Be	Arthur Delmar Joh	nson			Helen	William	S	
Maryland	2 sho and h is ma		19a. Informant's Name/Relationship (Typ			,			City or Town, State, Z	
	1 and Health iem 27	. 0	Blaine Thomas - S  20a. Method of Disposition			D Lenmans District (Name of or other place)			stown, Md.	
mor	Pages ent of nt: If it ry or o		Varial 2 □ Cremation 3 □Re 4 □ Donation 5 □ Other (Specify)	moval from State		matory or other piac n Mem. Pa		/04 н	agerstown,	Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service License		2:	2. Name and Addres	ss of Facility Mi	nnich Fu	neral Home	A TO SEE STREET STREET
	20529		OCA MANAGEMENT OF THE STREET O	////www.					town, Mary	land 21740 Approximate
	Dhysisian		23a. Part 1. Enter the disease, or conditions shock, or heart failure. List only on Immediate Cause (Final							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of the consequence of t	uence of):	1119	. 1			
	Examiner	_	Sequentially list conditions.	Due to (or as a consequ		ive 1	d earl	rai	Ihr s	
16	t t tursit	mlne	Equentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq.	derice ory.					
ó	te be executed ysician and se burial-transit	Examin	resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	cate be ohysici the bu	dlcal	d							
89 x	leath certificate t attending physi I for use as the t	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Date of deli	ivery
Box	death le atter ed for u	lclar	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐Feta 4☐Pregnant at time of d 9☐Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year
P.O.	that the ed by th detache	Phys	9 Unknown  Part II. Other significant conditions con		ulting in the I	inderlying cause give	en in Part f	23e. Did tob	acco use contribute to	the cause of death?
ds,	n requires that the death been signed by the atte should be detached for	d by	Part II. Other signment conditions con	mbulary to death but not res	aking in the c	and anything out as a give	on arract.			obably 4 □Unknown
cor	law requas been 2 shoul	olete						24a. Was ar		topsy findings available
l Re	The ate h page	Com						perforn	ned? death?	2 No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		oth Oth		h (Check only on		
of	Phys this ral dii	7: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatie	of 28c. Injun	y at	ome 5 ∐ Reside 28d. Describe ho	nce 6 Other (Spec w injury occurred	cify)
ion	Attending of death.	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Fear)	Injury	M 1	Yes 2 □ No			
Division of Vital Records,	or Atterder de Directe in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st fy)	reet, factory, office		28f. Location (Sti City or Town	reet and Number or Ru , State)	iral Route Number,
	To the Hospitel or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu			sician: To the best of my kno						
	the Ho in 24 t the Fu ipletely	Medical	опе)	ner: On the basis of examina and manner stated.	ation and/or in					
	Mit V	2	29b. Signature and title of certifier	Mus		29c. Licens	60396	25	9d. Date signed (Montl	r, Day, Tear) A
	"Jut		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type					2771
d	pr		FARIT M	JUNSHE	9,1	126 01	pul Ct	· , Hag	erstown	, M317/2
*	St. Regist	ate rar	31. Date filed (Month Day Year) 7 20	32. Registrar's Signa	Sture for	boxes		-		

State of Maryland / Department of Health and Mental Hygiene 2004 06559 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3:15 p. February 8 2004 Bertha Blanche Jones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glasgow Home Assisted Living Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 X F 2,\_ 83 Maryland Director 220-03-4405 Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural; or items 23s or 28s-f show environger or other treumatic event, the Medical Examiner must be notified at once. 1 XYes 2 No Dorchester Cambridge Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21613 U.S.A. 311 Glenburn Ave. Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10 College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 1% Father's Name (First, Middle, Last) Be Bertha Abbott James North 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 306 Grove Thorn Rd., Baltimore, MD Elizabeth Tooma sister Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State Old Trinity Churchyard 2/10/04 Church Creek, MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licenses Brim 700 Locust St., Cambridge, MD Duto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition AYJENIOSCIENTIC Heart yem Physician resulting in death) /Medical Obstance pulmonery Examiner Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? as been signed I 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ≥ es 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate has page 1□ No 1 TYes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Other 4 Nursing Home 5 Residence 6 V her (Specify) Living Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 3 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death After Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET CAMBRIDGE THANWY 300 NOMAN 2007 Registrary Signature

Registrar DHMH 17 Rev 1/2001

P.O. Box 68760.

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			For State	State of Marylan	•		Mental Hygiei	ne 2004	06560
			1 - State Registrar		Certifica	te of Death	Reg.	No.	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last	e Eliza		Johnson	Februar		3. Time of Death 8:15 PM
	Examin	er	4a. Facility Name (If not institution, give	- ^	1011	y, Town, or Location of Death	1.0	Ac. County of Death  DORCH	acian
Ī	Funeral Director		5. Social Security Number 6. Se	AVENUE AP X 7. Age (In yrs. 5		er 1 Year   If Under 24 Hrs S Days   Hours   Min.	B. Date of Birth (Month, Day, Ye	ar) 9. Birthpla	ace (State or Foreign ry) RYland
	yland wor		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Location			10	od. Inside City Limits
	death with the Maryland ms 23a or 28a-f show roust be nutified at	Funeral Director	MD Dorch  10e. Street and Number	ester	Cambr	i dge	10g.	Citizen of What Count	1 Pres 2 □ No
7	th with 23s or	al Di	214 Meteor A	Venue - Apt.	804	2/6/3		USA	
		Funer	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	S. 13. Was Dec If Yes, sp	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puerl 2 No Specify:	pecify Yes or No- lo Rican, etc.)	14. Race - America Black, White, e	
3	72 hours after natural', or ite	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	16a. Decedent's Us		166	. Kind of Business/Ind	
<u>,</u>	hin 72 9. an "nai	Completed	(Specify only highest grad	(ie completed)  College (1-4or 5+)	(Give kind of w life. DO NOT	work done during most of wo use retired)	rking		
7	iled wit Hygien ther th		17. Father's Name (First, Middle, Last)		Nurs		me (First, Middle, Maid	ounty Sch	col board
2	d be fi	o Be	James Russ	ell NonEl	eet SR.	На		NSON	
<u> </u>	shoul nd Me mark	ဥ	19a. Informant's Name/Relationship (T		19b. Mailing Addre	ss (Street and Number or Ru			Code)
, K	and 2 ealth a n 27 is ser trai		Cornelius	Johnson	420Le	onards La		oridge M	0.21613
Jore	ages 1 nt of H :: If ite		20a. Method of Disposition  1 ID Burial 2 □ Cremation 3 □ I	Removal from State	Place of Disposition (Nemetery, crematory of	other place)	212110	. Location Chyor Tov	a AAC
Saltin	mit. P. sartme sortani / injury		*4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service License				2/07 CO	P.A.	Jin Di
ă	Depa Impo any i		Janelle	. C. Hen	W 510	and Address   Facility RY FUNERO Washingto	w StiCan	Abridge 1	ND.21613
			23a. Part Enter the disease, or comp shoot, or heart failure. List only of	lications that caused the deat ine cause on each line.	h. Danot enter the me	ode of dying, such as cardia	c or respiratory arrest,	0 /	Approximate Interval Between Onset and Death
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	Examiner		Conventially list conditions	b	301.00 01/.				
-	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Entar Underfully Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):				
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2/60	ate be ex hysician the burial	lical		d				-	
SQ X	Jeath certificate I attending physical	/Mec	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of deliver	ry
O. Box	9 9 9	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown				Month I	Day Year
JS, T	gned gned	δ	Part II. Other significant conditions of	intributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?
Vital Records,	w require been si should t	Completed					24a. Was an autopsy	24b. Were autop	osy findings available
Ž Ž	The ate h page	Som					performed	l? _ death?	
/Ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	ath (Check only one)		
	Physic rthis ral dir	1.10	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 1 1 28b. Time of	28c. Injury at	dome 5 Residence 28d. Describe how i		)
0	Attending Physician: if death. ector: After this certific by the funeral director.	atior	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury M	Work? 1 ☐ Yes 2 ☐ No			
Division of	i Ditte	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fact fy)	ory, office	28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exert	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2 PM	2	29c. License number		Date signed (Month, L	Day, Year)
			· WE	) ~ "		D2575		2/6/04	P.
			30. Name and address of person who o			Avo Boshor	MD SICOI		
	St	ate	Robert B. Sanche 31. Date filed (Month, Day, Year B	2, M.D. 508 0 9 29 14 gistrar ssign	ature A	Ave., Easton,	IN STOOT		
	Regist		1.20	1	We so so	The same of the sa			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State Registrar		Cer	tificate of l	Death	2. Date of De	Reg. No.	200	4 065	
hysicia		Decedent's Name (First, Middle, Last					Month	Day	Year	3. Time of Deat	
/Medic	al	Frederic Henry K		1	Februa		2004 ounty of Death	7:25A			
Examin	er	4a. Fecility Name (If not institution, give			4b. City, Town, or	n					
		Washington Count 5. Social Security Number 6. Se		t hirthday)	Hagersto	If Under 24 Hrs	8. Date of Bir		sningto	on County	
ineral rector		13	M 2□F 92	Yrs.	Months Days	Hours Min.	April 2	y, Year) 1		nplace (State or For Intry) Jersey	
rector	-	063-09-2173 Usual Residence of Decedent					12		INCH		
Mon		10a. State 10b. County	10c. City, 1	Town or Lo	cation					10d. Inside City Lin	
in per l	ţō	Maryland Washing	ton Wil	lliam	sport			1 ☐ Yes 2			
128	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?			
23a c	aiD	16505 Virginia Ave	2		2179	95			5.A.		
nd other than "natural", or items 23s or 28e-f show event, the Medical Exerciner roust be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates:	11	Vas Decedent of H f Yes, specify Cuba I □ Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		. Race - Amer Black, White WI pecify:		
ica i	Completed	15. Decedent's Edi		16a. Deced	lent's Usual Occup	ation during most of wo	rkina	16b. Kind	of Business/I	ndustry	
Wed	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired	d)	9	- 1	- 1		
ther than	on		4	Viœ	Presider					erage Co.	
event.	ВеС	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Sumame)  Irene Kreitler						
arked itic e	70 E	Frederic H. Kass S									
yes 1 and 2 should be for Health and Mental hill tem 27 is marked of prother traumatic every	ij	19a. Informant's Name/Relationship (7 Frederic H. Kass									
		20a. Method of Disposition	cem	etery, cren	sition (Name of natory or other plac	сө)	Date		tion - City or 1		
nt: if		1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify			-	_ ,				g, Maryla	
Important: If ite any injury or ot QDC8.		21. Signature of Funeral Service Licen	500				The second second second		_	eral Home yland 217	
physician and mineral transit sthe burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	nce of):	(ne	em n.				T week	
by the attending phy tached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetel d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3	Ectopic pregnance Other (specify)	у		23	d. Date of deli Month	ivery Day Year	
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cate has been s page 2 should	Completed						24a. Was auto perfi 1 ☐ Yes		prior to death?	itopsy findings avai completion of cause 2  No	
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		0#	har	ath (Check only				
his	5	1 Yes 2 No	1 Minpatient 2 E	R/Outpatier 8b. Time o	1 3 DOA	4   Nursing	Home 5 Res 28d. Describe			ory)	
After	O	27. Manner of Death 1X Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk? ]Yes 2 □ No	200, 2000, 100				
To the Funeral Director: After to completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		e, farm, st			28f. Location City or To	(Street and wn, State)	Number or Ru	ıral Route Number,	
unera y fille	edical C	29a. Certifier 1 XCertifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowl niner: On the basis of examination and manner stated.	ledge, deat on and/or in	h occurred at the to vestigation, in my	ime, date and plac opinion, death occ	e, and due to the curred at the time	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)	
F. Bled	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date	signed (Monti	h, Day, Year)	
o the Fu			. 0 /		29c. License number				2.13.04		
_		muchaes	1. Muleuren	- M	0 0	4166-	)	1	11	. 09	
To the Fu		30. Name and address of person who	completed cause of death (Item 2		Print)	4166			/ /	. 09	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup>11, 2004 February **Physician** 11:00 Harry Gustave Koehler /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Crownsville 2069 Haverford Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 16 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) 920 **Funeral** Days Hours Pennsylvania 83 198-10-9607 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Exercites must be notified at 1 ☐ Yes 2 No Director Crownsville Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21032 United States 2069 Haverford Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Item any injury or other traumatic event, the Medical Eventheriance. 1 Mayes 2 No 1f Yes, Give Year or Dates: 1943-1946 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Inspector 12 areospace 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Catherine Neary Frederick G. Koehler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2069 Haverford Drive Corwnsville, MD 21032 Christian Koehler/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 @Cremation 3 ☐ Removal from State Feb. 14, 2004 Baltimore, MD Metro Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Funeral Service 147 Duke of Gloucester St. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ should be 1 Yes 2 No 3 Probably 4 Whknown Completed been s 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 After this certificate has 22 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Nichem 6 Other (Specify) 1 Yes 2 No Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral L Hospital entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Morical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture 4005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 116 Defense Hwy. Suite 400 Annapolis, MD 21401 Howard D. Goldstein, M.D. 31. Date filed (Month, Day, Year) gistrar's Signature State 7 FEB Registrar

**ORIGINAL** 

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State of Maryland / Department of Health and Mental Hygiene 2004	06563
Clate of Maryland / Bepartment of Health and Mental Hygietie C O 4	00000
Certificate of Death	

			1 - State Registrar		Cei	rtificate of D	eath	Reg	g. No.			
			1. Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death		
	Physic		Maryetta Lane					Februar	TV 13. Year	04 0518 M		
	/Medi Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or L	ocation of Deat	<del></del>				
	LAGITIII	iei P	Memorial H									
	T		5. Social Security Number 6. S		(In yrs. last birthday)			8 Date of Birth				
31	Funeral Director			☐M 2007F	78 Yrs.	Months Days	Hours Min.	(Month, Day, )				
	/land		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits		
	he Man 28a-f sh cuffied	Director	Maryland Carolin	e	Greensbo					1 ☐ Yes 2 No		
	ath with		10e. Street and Number  13570 Greensboro			10f. Zip Code 21639			U.S.A.			
21215-0036	d within 72 hours after death with the Maryland Jiene. I than "natural", or Items 23a or 28a-f show I'ra Medical Exart are must be invitted at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0	1 Yes, specify Cuban,	, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Black, Whi	te, etc.		
15-0	n 72 h "natu	Completed	15. Decedent's Ed (Specify only highest gra	fucation ide completed)	(Give	dent's Usual Occupati kind of work done dui DO NOT use retired)	ion ring most of wor	rking	3b. Kind of Business	/Industry		
212	filed within Hygiene. other than "	omp	Elementary/Secondary (0-12)	College (1-4or 5+	+)	emaker			own ho	me		
b	othe	Be C	17. Father's Name (First, Middle, Last,	*	1202		2. Date of Death Month Day 7 ary 13, 2004 051  February 14. Country Death Talbot  February 12, Birthplace (State of Birth Indian, Black, White, etc.)  Specify: White  February 13, 2004 051  February 10, Birthplace (State of Birth Indian, Black, White, etc.)  Specify: White  February 10, Birthplace (State of Business/Industry 10, Black, White, etc.)  Specify: White  February 10, Black, White, Ed.  Specify: White  February 10, Black, White, etc.  Specify: White  February 14, Bace-American Indian, Black, White, etc.  Specify: White  February 14, Bace-American Indian, Black, White, etc.  Specify: White  February 14, Bace-American Indian, Black, White, etc.  Specify: White  February 14, Bace-American Indian, Black, White, etc.  Specify: White  February 14, Bace-American Indian, Black, White, etc.  Specify: White  February 14, Bace-American Indian, Black, White, etc.  Specify: White  February 14, Bace-American Indian, Black, White, etc.  Specify: White  February 14, Bace-American Indian, Black, White, etc.  Specify: White  February 14, Bace-American Indian, Black, White, etc.  Specify: White  February 14, Bace-American Indian, Black, White, etc.  Specify: White  February 14, Bace-American Indian, Black, White, etc.  Specify: White  February 14, Bace-American Indian, Black, White, etc.  Specify: White  February 14, Bace-American Indian, Black, White, etc.  Specify: White  February 14, Bace-American Indian, Black, White, etc.  Specify: White  February 14, Bace-American Indian, Black, White, etc.  February 14, Bace-American Indian, Black, White,					
Maryland		10	John T. Guessford				Pearl F	ord				
ary	A DE LE		19a. Informant's Name/Relationship (	Гуре, Print)	19b. Mailin	ng Address (Street an	d Number or Ru	ral Route Number, (	City or Town, State,	Zip Code)		
	C = 01 L	3	Walter A. Lane	spouse	13570	Greensbo	ro Road	Greensb	oro, MD	21639		
ore.	8 = = 0	1	20a. Method of Disposition	•	20b. Place of Dispo					Town, State		
altimore,	Pages nent of P ant: If its ury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		1		1	6/2004 G:	reensboro	, Maryland		
Balt	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licer	lsee	22 F:	Name and Address leegle and	of Facility Helfen	bein Fune	ral Home	PA 630		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused t	the death. Do not ente	er the mode of dying,	such as cardiac	or respiratory arrest	yjana zi t,	Approximate		
	Physician /Medical		Immediate Cause (Final		drogence	Shock				Onset and Death		
	/Medical		disease or condition resulting in death)	d	consequence of):	-1104						
	Examiner		Sequentially list conditions	b								
9	outed and a	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							
	and and I-tran	хаш	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):							
68760,	certificate be executed Iding physician and ise as the burial-transit				consequence on.							
387	icate phys s the	/Medicai		. d								
Вох			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		Ectopic pregnancy						
P.O. E	ires that the dea signed by the at I be detached fo	Physiciar	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□ Unknown		Other (specify)			Month	Day Year		
	law requires that the death as been signed by the atter 2 should be detached for u	by	Part II. Other significant conditions of Pneumon	nia		derlying cause given	in Part I.					
S	w require been significant	iete	Congesti	ne Heart	Farlure			24a Wasan	24h Were au	itonsy findings available		
of Vital Records,	The ate ha	Completed						autopsy performe	prior to death?	completion of cause of		
f Vit	Si Si	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 VInpatient	t 2 ER/Outpatient	Other			e 6 □Other (Spe	cify)		
n	nding Ph tth. :: After th e funeral	ation:	27. Manner of Death  1	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury al Work? M 1 ☐ Ye		28d. Describe how	injury occurred			
Division	al or Atter after des I Director d in by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur- building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	at and Number or Ru State)	ural Route Number,		
	To the Hospitel or Attending I within 24 hours after death.  To the Funaral Director: After completely filled in by the funar	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of niner: On the basis of e and manner state	examination and/or inv	occurred at the time, estigation, in my opin	date and place, ion, death occur	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	s stated.  to the cause(s)		
	To th within To th sompl	Me	29b. Signature and title of certifier			29c. License n	umber	29d.	. Date signed (Monti	h, Day, Year)		
	, ,,,,		> IL	HarouL	aura Di	n D5	5484		2-13	-2004		
			30. Name and address of person who on the Laura Jin, MD		ath (Item 23a) (Type, F ashington		Fast	on. Marvla	and 21601			
	Sta		31. Date filed (Month, Day, Year)		's Signature			_,,				

State of Maryland / Department of Health and Mental Hygiene 06564 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2004 BRENDA SUE LISTER FEB. 15, 1:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 505 CHESTERFIELD AVENUE CENTREVILLE QUEEN ANNE'S | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JUNE | 20,1958 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F 45 218-70-3069 Director MARYLAND Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral, or items 23s or 28s-f show Exercises must be notified at 1 ☐ Yes 2 X No MD QUEEN ANNE'S QUEENSTOWN Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1018 BENNETT POINT ROAD 21658 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Iter any injury or other fraumatic event, the Medical Example once. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 -0-BOOKKEEPER LUMBER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MILLS MIDDLETON SHIRLEY WALLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 CHESTERFIELD AVE., CENTREVILLE, MD 21617 SHIRLEY MIDDLETON/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State WOODLAWN MEMORIAL PARK 2-17-2004 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furfere Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or or inclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** monto disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Nes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performed3 page certificate 1 Yes 2 No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other Specify S HOME 1 Yes 2 No ö 2 2 ER/Outpatient 3□ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending within 24 hours are: were To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number address of person who completed cause of death (Item 23a) (Type, Print) 6 filed (Month, Day Year) 31. Date 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2004 06565 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Andrew A. Lemeshewsky February 15, 2004 9:15 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months 1⊠M 2□F 4, Yrs. 80 1924 229-16-3982 Feb. Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 XNo Anne Arundel Arnold Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 1058 Ulmstead Circle 21012 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No 1945— If Yes, Give Year or Dates: 1974 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Naval Officer U.S. Military 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Horbachevsky Anthony A. Lemeshewsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol P. Lemeshewsky 1058 Ulmstead Circle Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 16 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 2004 Baltimore, MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service, icensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart four. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe has page 2 this certificate 1 Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After or Attanding Natural 5 Pending investigation 1 □ Yes 2 □ No death. 2 Accident the **Director:** 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and hitle of certifi who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Ke 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State FEB 1 7 2004 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 14

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Feb. 1303 м 2004 **Physician** 16, Meredith C. James /Medical 4c. County of Death
Caroline 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Preston Farm near 4886 Schulke Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of 8 irth (Month, Day, Vr. 03/05/37 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 □ F Maryland 218-34-8476 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County or Items 23a or 28a-f show afrer court be notified at 1 Yes 2 No Preston Funeral Director Caroline 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21655 United States 4886 Schulke Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: or Itams filed within 72 hours after 1 ☐ Never Married 2 🙀 Married White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 the Medical Expr þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) Food Industry Sales Representative 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if Item 27 Is marked other t any injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Louise Gadow Lee Meredith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 250, Preston, MD 21655 19a. Informant's Name/Relationship (Type, Print) Grace H. Meredith/ Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 02/19/04 Preston, Maryland Junior Order Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. Mulail PO Box 43, Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Atherisclesofic heart disease Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): P.O. Box 68760. the attending physicien certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ page 2 should be 3 ☐ Probably 4 🖼 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 ☐ Yes 2 ☐ No 1□ Yes 2 **X** No To the Hospital or Attanding Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Diractor: All completely filled in by the fu м 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of a life 30. Name and address of pers 11 who completed cause of death (Item 23a) (Type, Print) 300 AURORA ST. CAMBRIDGE MD. 2/6/3 H122AC MUHAMM AD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For	State of Ma	aryland	d / Depa	artme	nt of H	ealth ar	nd Mei	ntal Hygi	ene 2 N	n I.	06567
	_		1 - State Registrar			Ce	rtifica	te of L	Jeath		Date of Deat	9. 110.	0 4	3. Time of Death
	Physici	an	Decedent's Name (First, Middle, Las Charles Russel	McCauley							Month	Day	Year	3. THIS OF DEALT A
	/Medio	al	Charles Russel  4a. Facility Name (If not institution, give	<u>·</u>	-		4b. Cit	. Town, or	Location of	Death	tebrua	4c. County	of Death	1127
	Examir	ier	Washington Coun		1				rstowr				shin	aton
	Funeral		5. Social Security Number 6. S	9x 7. Ag		ast birthday)		er 1 Year	If Under 24		Date of Birth (Month, Day,			plece (State or Foreign
	Director		219-44-3461	<b>(</b> )√M 2□ F	58	Yrs.	Months	Days	Hours	Min.	an.30,	946		y l and
	р ,		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	ocation							0d. Inside City Limits
	shov	ä			Too. Oily			amspo	r+					XXYes 2 □ No
	28a-1	by Funeral Director	Maryland Washi	191011		VV		ip Code			10	og. Citizen of W	/hat Cour	ntrv?
	with with		10B South Conoce	ocheague 9	troot	ŀ			1795				USA	
	ms 2;	era	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13.	Was Dec			in? (Specif	y Yes or No- an, etc.)	14. Race	- Amend	can Indian,
9	after or Ite	Fü	1 Never Married	Armed Forces? 1XXYes 2 ☐ I If Yes, Give		,	1 Yes, sp		Specify:	ruento nic	an, etc./	Specify	k, White,	etc.
93	ours Frail,	dby	3 Widowed 4 Divorced	Year or Dates:	1900									White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show ha Modical Examirer must be mullisd at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	kind of w	ual Occupa rork done c use retired	luring most o	of working		6b. Kind of Bu	siness/In	dustry
12	withir ene. than	щ	Elementary/Secondary (0-12)	College (1-4or 5	5+)			Plumb				Plum	hina	
	filed with Hygiene. other that		17. Father's Name (First, Middle, Last)		1	1103	101	i i dilib		's Name (F	First, Middle, N	laiden Sumam		
lan	ould be Mental Marked o	To Be	Carl Edmond McC	auley					Daisy	y Lu	cille	Palmer		
Maryland	2 should and N is main		19a. Informant's Name/Relationship (	Type, Print)		19b. Maili	ng Addre	ss (Street a	and Number	or Rural F	Route Number,	City or Town,	State, Zip	Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Exemples trausible notified at		Nancy McCauley -	Wife					coche					rt,MD 21795
ore	of He		20a. Method of Disposition  XXBurial 2 Cremation 3	Removal from State	20b. Pi	ace of Disperent of the second	osition (Namatory or	ame of other plac	θ)	Date	9   2	20c. Location -	City or To	own, State
Ë	ment tant: jury c		* 4 □Donation 5 □ Other (Specific	201	Gree							illiams	port	,Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra ance.		21. Signature of Funeral Service Lice	sgfe )					eraglity					D 21705
			23a. Parti. Enter the disease, or com shock, or heart failure. List only	olications that caused	the death	. Do not en	ter the mo	CONC	COCNE	ague ardiac or ri	ST.WII	i i amspo	FT, M	D 21795 Approximate
. 8	- 104		shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.	0		,	17.	1.				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a conseque	ence of):	non	ary	HIM	sse		slare		
A Part	Examiner		O	- ather	osc	lerot	i (	and	ovas	cula	n De	sluse		
63,0	п ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience of):								
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	0.0000000	10000 of):								
760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	cal E		D00 10 (01 &3	a consequ	ionico or <sub>j</sub> .								
687	physicate sthe			d										
Box (	certif nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnar	ncy						23d. Date	e of delive	əry
	death e atter	iciai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			⊒Ectopic ⊒ Other (	pregnancy specify)				Mor	ith	Day Year
P.O.	t the by the tache	Physician/Med	9 □ Unknown	9 Unknown										
	The law requires that the death certificat the has been signed by the attending phyage 2 should be detached for use as the		Part II. Dther significant conditions of	ontributing to death b	ut not resu	ulting in the u	inderlying	cause give	en in Part I.					he cause of death?
ord	equir sen si tould	ted									1 V8	s 2 No	3   Proc	pably 4 Minknown
ec	law law law las be	Completed by								_	24a. Was ar autops perform	/ P	Vere auto rior to co leath?	ppsy findings available mpletion of cause of
H											1□ Yes 2	12 No 1	Yes	2 DXN0
Vit.	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Hospitaf:		ER/Outpatie		Othe	200		Check only one	9) nce 6 □Othe	- (Canai	
of	his ld	: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpation	IIV	28b. Time (		28c. Injun	at Nuis			w injury occurr		у)
lon	nding P th. : After t e funera	tion	1 Matural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	y Year)	Infury	М	Worl	<br Yes 2 □ N	lo				
Division of Vital Records,	Attendii er death. rector: A by the fu	tiffe	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of fn			reet, facto	ory, office		281	Location (St.		ar or Rura	al Route Number,
ā	ital or rs aft al Dii	Cer												
	Hosp 4 hou Fune fely (ii	Medical Certification:		ysician: To the best niner: On the basis of	f examinat									
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Med	29b. Signature and title d certified	and manner st	a.8U.		2	9c. Licenso	number		25	d. Date signed	(Month,	Day, Year)
			1 / //	lesent	In			14.	408	84		2.0	-06	4
	4-971		30. Name and address of person who	completed cause of	death (Item	23а) (Туре	, Print)	[-]	,			0		!
2	۲		Dr. Gilbert	Jashing	m	Coll	rty	Hop	- 14	Mg.	Md .	2174	0	
	St	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ture	1 . 21			1				
	Regist	rar	FEB 0 9 1	LUUT ARE	(dans)	N. 16	BUNER	o stalls						

		1	For State Registrar	State of Mary	Cei	rtificate of L	Death	R	1eg. No. 200 [.			
		_	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Year	3. Time of Death		
F	hysicia Medic/	_	Karen Ann Middleka	auff				Februa	ry 11, 2001			
E	Examin		4a. Fecility Name (If not institution, give st.			4b. City, Town, or		1	4c. County of Deeth			
			Washington County			Hagerst	LOWN If Under 24 Hrs.	8. Date of Birth	gton rthplace (State or Foreign			
	uneral		5. Social Security Number 6. Sex	M 2QF	n yrs. last birthday)  61. Yrs.	Months Days	Hours Min.	(Month, Dev	, Year)	aryland		
Di	rector	-	215-36-5814 Usuel Residence of Decedent	X	64 Yrs.			July 1	7, 1737	aryrand		
and	M TI		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits		
Many	Help	ţō	MD Washingt	ton	Hagerst	own				1 Yes 2 □ No		
the	r 28a	Director	10e. Street and Number Apartmet			10f. Zip Code			10g. Citizen of What C	Country?		
death with the Maryland	138 o		11 West Baltimore			21740			U. S. A.			
deat	me Z	Funeral		2. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh			
after	or Ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify: Wh	ite		
hours after	an "natural", or Itama 23a or 28a-1 show Medical Examinar must be ritilified al	d by	3 Widowed 4 Divorced	Year or Dates:	40- P	dende Heinel Onnie	etion		16b. Kind of Busines	e/Industry		
Z I Z I 3-0030 id within 72 hours af giene.	nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wo	rking	TOB. TAIRS OF ESSITIOS	amadany		
withir A	n M	d d	Elementary/Secondary (0-12)	College (1-4or 5+)	_	erator	,		Answering	Service		
	d other than event, the M		17. Father's Name (First, Middle, Last)						Maiden Sumame)			
<b>—</b> — —		To Be	Robert F. Stouffe:	r			Margar	et Virgi	nia Crunkl	eton		
Maryland d 2 should be file th and Mental Hy	marked imatic e	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ng Address (Street	and Number or Ri	ıral Route Numbe	r, City or Town, State,	Zip Code) 21740		
Ind 2	27 le		Allan L. Middleka	auff/Husba	nd Apt.	809, 11 7	West Bal	timore,	Street, Ha	gerstown,MD		
s 1 a l	item othe		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. Location - City of	r Town, State		
Page Page	nt: If		1 Burial 2 ☐ Cremation 3 ☐ Re 1 Donation 5 ☐ Other (Specify)	emoval from State		ven Cemete		4/2004	Hagerstow	n, MD		
Darrit. Pages 1 at Department of Hea	Impurant: If item 27 le marked any njury or other traumatic ev 9066.		21. Signature of Funeral Service License	10	2	2. Name and Addre	ss of Facility Res	st Haven	Funeral C	hapel		
Ď ää	EEG	10	5. Mark Su	m					Hagerstown	, MD 21742		
		Ž.	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	carous that caused the	e death. Do not en	ter the mode of dyin	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death		
Phy	sician		Immediate Cause (Final disease or condition	Servie	Shock	,				Onset and Death		
/M	ledical		resulting in death)	Due to or as a c	onsequence of):							
Exa	aminer		Sequentially list conditions, b.	Due to for a c	consequence of):	failure						
D	Ħ	iner	if any, leading to unmediate cause. Enter Underlying Cause (Disease or injury									
ecute	trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a c	an equence of):	3						
Š,	cian a	Ω .			equonos ory.							
Records, P.O. Box 68/60, The law requires that the death certificate be executed	physician and s the burial-transit	dlcal	d	l								
OX b	ed by the attending podetached for use as	4	IF FEMALE:	3c. If yes, outcome of	pregnancy				23d. Date of d	elivery		
Bath c	atten for us	lan	in the past 12 months?	1 Live birth 2 ( 4 Pregnant at tir	Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>	/		Month	Day Year		
j ş	the	ysic	1 □ Yes 2 MNo 9 □ Unknown	9 Unknown								
that	ed by deta	by Physiclan/M	Part II. Other significant conditions con	tributing to death but i	not resulting in the o	underlying cause giv	ren in Part I.	23e. Did to	obacco use contribute	to the cause of death?		
ds,	signed Id be de							101	Yes 2□No 3□	Probably 4 Unknown		
OC A	should	Completed						24a. Was	an 24b. Were	autopsy findings available		
A é	page 2	m							rmed? death	o completion of cause of		
<u> </u>	certificate rector, pag		25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only o		55 2 140		
of Vita Physician:	recto	o Be	evaminer?	lospital:	2 ER/Outpatie	ent 3 DOA Oth	100		dence 6 □Other (Sp	pecify)		
o g	ar this aral d	n: To	27. Manner ol Death	28a. Date of Injury (Month, Day )	28b. Time	-			how injury occurred			
O gig 4	a fun	atlo	1 ANatural 5 ☐ Pending 2 ☐ Accident investigation	(Mollin, Day 1	667 Injury		Yes 2 □ No					
	after death Director: A d in by the f	ific	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, farm, s	treet, factory, office		28f. Location (S City or Tox	Street and Number or wn, State)	Aural Route Number,		
Vision	<u> </u>	Certification:		3,	(-,,,				777			
DIVISION Alten	o = o		29a. Certifier 1 Certifying Phys	sician: To the best of	my knowledge, dea xamination and/or i	ith occurred at the til	me, date and place	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated.		
Divisi	nours a uneral I ly filled	ca	(Check only 2 Medical Evamin							ne (n (iie nanze(z)		
DIVISION HOSPITAL OF Atten	in 24 hours a the Funeral I pletely filled	edical	(Check only 2 Medical Examilions)	and manner state	d.							
DIVISION TO the Hospital or Atten	within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Examin	and manner state	d.	29c. Licens			29d. Date signed (Mo			
To the Hospita	within 24 hours a  To the Funeral I  completely filled	Medical	(Check only 2 Medical Examilions)	and manner state	(t)							
To the Hospital or		Medical	(Check only 2 Medical Examination)  29b. Signature and title of certifier  30. Name and address of person who co	and manner state	(1)	29c. Licens	-6561	1.10,000	29d. Date signed (Mo			
To the Hospita	り	Medical	(Check only 2 Medical Examile one)  29b. Signature and title of certifier	and manner state	(1) hth (liom 23a) (Type NT AETN	29c. Licens	-6561	KENTOW	29d. Date signed (Mo			

		For	State of M		Dep	artment		and Me	ental Hygi	iene		00000
		Stete Registrar			Ce	rtificate	of Death				2004	
Physicia	an	Decedent's Name (First, Middle,							2. Date of Death Month	Day	Year	3. Time of Death
/Medic	al .	Francis 4a. Facility Name (If not institution,		Martell		4h Cih To	own, or Location		Februar		2004 ounty of Deatle	
Examin	er	7550 Bond Str									alvert	
Funeral			S. Sex 7. Ac	e (In yrs. last	birthday)	If Under 1			B. Date of Birth (Month, Day,			hplace (State or Foreign untry)
Director		001-14-7418	12XM 2□F	81	Yrs.	Months [	Days Hours	Min.	Month, Day, Dec. 1	6,	1922 N	lassachusetts
pu ,		Usual Residence of Decedent		40- Cit. T.								
aryla:	_	10a. State 10b. County		10c. City, To								10d. Inside City Limits 1 ☐ Yes 2 X No
the M	ect	MD Calve	rc	St.	Leo	nard 101. Zip C	'ode		10	no Citiza	on of What Co	
death with the Maryland ms 23e or 28e-f show I must be notified at	Funeral Director	7550 Bond Stree	÷				20685				_	
death ms 23	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13.		nt of Hispanic Or y Cuban, Mexica	rigin? (Spec			ed Stat	rican Indian,
or ite		1 ☐ Never Married 2X Marrie	Armed Forces? d 1 X Yes 2 ☐ If Yes, Give	No WWII			y Cuban, Mexica <b>X</b> No <i>Specify</i>		ican, etc.)		Black, White	
hours after tural; or ite	d by	3 Widowed 4 Divorced	Year or Dates:			10 105 20	ANO Specily			5	pecify: WI	nite
Z I Z I D-UUSO d within 72 hours alt piene. rr than "natural", or	Completed	15. Decedent's (Specify only highest		16	6a. Dece (Give	dent's Usual (	Isual Occupation 16b. Kind of B work done during most of working T use retired)					Industry
within 72 ene. than "na!	d m	Elementary/Secondary (0-12)	College (1-4or	5+)		orney	reurea)			La	aw	
7 7 2 4		17. Father's Name (First, Middle, La			ACC	Officy	18. Moth	er's Name (	First, Middle, N	faiden Si	umame)	-
	To Be	Frank J. Marte	ell				Ka	athlee	n O'Cor	nor		
Share and share		19a. Informant's Name/Relationshi	p (Type, Print)	1	9b. Maili	ng Address (S	Street and Numb	er or Rural	Route Number,	City or 1	Town, State, Z	(ip Code)
ore, Missing 1 and 2 and		Carol E. Marte	ell (WIFE)				Street S	St. Le	onard,	Mary	land 2	20685
• • •		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 ☐ Removal from State			osition (Name matory or othe		Da			ation - City or	
altImor nit. Pages artment of ortant: If it injury or o		`4 ☐ Donation 5 ☐ Other (Spe	ecify)	Metro			rematory					
Baltimo permit. Page Department of important: if any injury or ance.		21. Signature of Puneral Service L	//	1005			Address of Facil					
		1-c/0,		1095							epublic	Approximate
		23a. P. 1. Enter the disease, or particle, or heart failure. List of	nh cause on each li	ine.	o not en	ter the mode (	or dying, such as	s cardiac or	respiratory arre	sst,		Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- a Metas			unen	docrin	0 7	umor	_		months
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	ē	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. — Due to (or as	a consequenc	ce of):							
f 60, ate be executed sysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events	c									
<b>6U,</b> be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequenc	ce of):							
ate be expression hysician the buria	licai		d									
BOX 68 eath certificat attending phy for use as the	Physician/Med	IF FEMALE:	200 16 1100 011400001				_					
BOX eath cert attendin for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal dea	ath 3[	□Ectopic preg				23	<li>d. Date of deli Month</li>	ve <b>ry</b> Day Year
at the de by the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant a 9□Unknown	it time of death	1 5(	Other (spec	GIIY)					
e e		Part II. Other significant condition	s contributing to death !	but not resultin	g in the ι	underlying cau	use given in Part	I.	23e. Did tob	acco use	e contribute to	the cause of death?
dS,	d by								1 □ Ye	s 2 <b>X</b>	No 3□Pro	obably 4 Unknown
COTC	jete								24a. Was ar	1	24b. Were au	topsy findings available
The law cate has a page 2 s	Completed								autopsy perform	ned?	prior to d death? 1 ☐ Yes	completion of cause of 2 No
VItal HECOrdS, sicien: The law requires t certificate has been signt irector, page 2 should be	BeC	25. Was case referred to medical					26. Plac	e of Death (	Check only one		1 163	2,2,110
T V I Vysici	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1   Inpati	ent 2 ER/	Outpatie	nt 3 DOA	Other: 4 🗆 N	ursing Hom	e 5 Reside	nce 6[	Other (Spec	cify)
On Of \ ding Physi h. After this c		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28l	b. Time o	of 280	c. Injury at Work?		d. Describe ho			
SIO teath. tor: A the fu	cati	2 Accident investigation in Suicide 6 Could not	ation			М	1 □ Yes 2 □					
DIVISION OT  I or Attending Phys after death. Director: After this Lin by the funeral d	Certification:	4 Homicide determine	289. Place of th	jury - At home tc. (Specify)	, farm, st	reet, factory,	office	28	If. Location (Str City or Town		Number or Ru	ral Route Number,
pital purs surs seral	ŭ	29a. Certifier Certifying	Physicien: To the best	of my knowler	dae dea	th occurred at	t the time, date a	nd place, an	d due to the ca	use(s) a	nd manner as	stated
24 hose Fun	edicai	(Check only 2 Medical E	xeminer: On the basis of and manner si	of examination	and/or ir	vestigation, in	n my opinion, de	ath occurred	d at the time, da	ate and p	lace, and due	to the cause(s)
DIVISION Of VITA  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely titled in by the funeral director,	Me	29b. Signature and title of certifier		0		29c.	License number		29	d. Date	signed (Month	n, Day, Year)
		1 And An	Q4-77	50			D 590	61		Feb.	17, 2	2004
		30. Name and address of person w										
10+1		Arati Patel		40				ce Fre	derick,	MD	20678	
Sta Registi		31. Date filed (Month, Day, Year)	1 8 2004	s Signature	K	Span	K)					

		For	State of Marylan 7818 PER FH G82	nd / Depa			=	_	, 06570	
Physic		1- State Registrar AMEND ITEM #5,1 1. Decedent's Name (First, Middle, Last) William Alexan		-	imoato or i	Joann	2. Date of Death Month Feb.	Day Year 8, 200	3. Time of Death	
/Med Exam		4a. Fecility Name (If not institution, give str 43 W. McKinsey	eet and number)			Location of Death	k	4c. County of Deat Anne A:	h	
Funera Directo	١ ١	5. <b>192</b> i <b>5:03</b> ity <b>18835</b> 6. Sex	7. Age (In yrs. 91		If Under 1 Year Months Days	Il Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 30,	9. Bin 1912	hplece (Stete or Foreign puntry) PA	
ם		Usual Residence of Decedent  10a. State 10b. County  MD Anne Aru		ty, Town or Lo	ocation Severna P	ark			10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
death with the Maryland ms 23s or 28s-f show	Director	10e. Street and Number			10f. Zip Code	146	10	g. Citizen of What Country?		
ter ter	by Funeral	43 W. McKinsey Rd,  11. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Divorced	ADC. #103  2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
within 72 hours af ene." returned; or then "netural; or the wedlest Exam	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4 or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work )	ing	6b. Kind of Business/Industry  Westinghouse		
IBRO Z IZ I Id be filed within ental Hygiene. ked other than ' ic evant, La Me	To Be Col	17. Father's Name (First, Middle, Last)  A. Camp Streamer C	4 HARLES A. MECHE	1	Officiace A	aiden Sumame)  CHARLOT				
OTC, Marylan es 1 and 2 should be of Health and Mental fitam 27 is marked i r other traumatic ev		19a. Informant's Name/Relationship (Type Ethelyn Mechesney/ 20a. Method of Disposition	Wife 20b.	19b. Maili 43 W		y Rd., Ap	ot. #105, Date 2	Oc. Location - City or	Pk, MD 21146 Town, State	
Baltimor permit. Pages Department of Important: If it any injury or or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Superal Server 4 except	I	2	Crematory  2. Name and Address  Sarranco &	ss of Facility	2004	ma Park F	MD uneral Home VD 21146	
760,  b be executed  Wedica Examine  e burial-transit	ıl	23a. Part. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  5 aguentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a conserve CLMUM  Due to (or as a conserve)	quence of):	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death Oset An Death	
Sox 68 ath certificat attending phy or use as th	Physician/Medica	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Ø No 9 ☐ Unknown	ic. II yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	□Ectopic pregnancy	,		23d. Date of delivery Month Day Year		
ds, P.O. I uires that the de signed by the a id be detached f	by	Part II. Other significant conditions conf	ributing to death but not re	sulting in the	underlying cause giv	en in Part I.		acco use contribute t s 2 □ No 3 □ P	o the cause of death? robably 4 Unknown	
Il Records, The law requires t cate has been signe	Completed						24a. Was ar autops perform 1 Yes 2	nrior to	utopsy findings available completion of cause of s 200 No	
Division of Vital Re To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	tion: To Be	25. Was case referred to medical examiner?  1  Yes 2 No H.  27. Manner of eath 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 [ 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time Injury	of 28c. Injui Wor	er: 4 Nursing H	th Check onl	nce 6 □Other (Spe	ecify)	
Division ( To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, larm, s	treet, factory, office		28l. Location (Sti City or Town	eet and Number or F , State)	lural Route Number,	
e Hospite 124 hours te Funera	edical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kr er: On the basis of examinand manner stated.	nowledge, dea nation and/or i	ath occurred at the ti nvestigation, in my o	me, date and place ppinion, death occu	, and due to the ca rred at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)	
To th withir To th comp	Me	29b. Signature and title of certifier	•			5259		d. Date signed (Mon		
		30. Name and address of person who co	PERE NO			3 Mero	Cil Pack	WAY ANA	Polic Moe1901	
	State strar	31. Date filed (Month, Day, Year) -FEB 1 7 20	32. Registrar's Sign	nature /	beek					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Rag. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Lassie Maxie 10:10 A M 13, 2004 February /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖺 F 88 220-15-4741 Tennessee May Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State rai, or items 23a or 28e-f show Examiner must be notified at 1 ■Yes 2 No Annapolis Maryland Anne Arundel Director 10f. Zip Code 21403 10g. Citizen of What Country? 10e. Street and Number 918 Jackson Street United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 10 · Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: þ 3 Widowed 4 Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) then Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 6 and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown Floyd Bowlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health ar Important: If Item 27 is any injury or other trau 15 Cypress Road Annapolis, MD 21403 Boyd Maxie/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Feb. 16, 2004 Annapolis, MD Hillcrest Cemetery <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licenses Ly 147 Duke of Gloucester St. Annapolis, MD 21401 I Scott 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brecus **Physician** Calcinoma /Medical Due to (or as e consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events satisfies in dooth). Due to (or as a consequence of). The law requires that the death certificate be executed use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the all 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 certificate 1 ☐ Yes or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification; To this 28a. Date of Injury (Month, Day Year) 27 Manner of Jeath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. ; after death 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signa and title of certifier CHOPKA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Aditya Chopra 600 Ridgely Ave. Suite 600 Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 17 2004 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

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			1 - State Registrar	State of M	arylar				lealth a		ental Hy	_	.2004	06	572
			Decedent's Name (First, Middle, Last	it)						1	2. Date of De	aath		3. Time of	Death
	Physici /Medic		Gerald J	L. Morais							Month Februa	ry ´	ay Year 13, 2004	11:00	$P^{M}$
П	Examin		4a. Facility Name (If not institution, give	street and number	)		4b. Cit	y, Town, or	Location of	of Death			c. County of Deal		
			University of Ma					Baltir		0411-					
	Funeral		5. Social Security Number 6. S	MM 2□F		last birthda Yrs.	y) If Und Month	er 1 Year S Days	If Under Hours	Min.	8. Date of Bit (Month, Da	₃у, Үөа	r)   Co	hpiace (State o	
	Director		016-34-9525 Usual Residence of Decedent		58						March	20,	1945 Mas	sachuse	etts
	yland		10a. State 10b. County		10c. Ci	ty, Town or	Location							10d. Inside C	ity Limits
	9 Mar	ctor	Maryland Anne Ar	undel		Edgew	ater							1 ☐ Yes	2 📉 No
	or 28	Oire	10e. Street and Number					ip Code				10g. C	itizen of What Co	untry?	
	ath w	rai	199 Cardamon Driv					2103					USA		
36	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other then "netural", or items 23s or 28e-f show imatic event, the Madical Examiner roust be naithed at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Yes 2 X If Yes, Give Year or Dates:	?	J.S. 13			ispanic Ori in, Mexican Specify:		cify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: W		
Ž	2 hou	ted	15. Decedent's Ed	lucation		16a. Dec	edent's Us	ual Occupa	ation			16b.	Kind of Business/	Industry	
2	thin 7 e. en "n	nple	(Specify only highest gra	College (1-4or	5+)	life	O NOT	use retired	during mosi ()	t of workin	ng				
7	filled wi Hygien other th	Completed		5+			Denti	.st					Dentistr	У	
Maryland 21215-0036	m = 0 =	Be	17. Father's Name (First, Middle, Last)  Lionel T. Mor					18. Mother's Name (First, Middle, Maiden Sumame)  Lucienne G. Gaudette							
ž	hould d Mer marke matic	၉	19a. Informant's Name/Relationship			105 145	iling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
<u>S</u>	d 2 s th an trau											-			
စ်	Heal Heal tem 2		Jean B. Morais/ W 20a. Method of Disposition	Tie	20b. l	Place of Dis	position (N	ame of		e, Eo	gewate	20c. I	MD 21037 Location - City or	Town, State	
ê	Pages ent of nt: If ry or		1 ☐ Burial 2 【Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify			cemetery, cr alas C	-		, ,	2–18–	04	Ede	gewater,	Marvla	bne
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licen	<u> </u>					1				las Fune	_	
ñ	Per la participa de la partici		Mont Villali	2			2973	Solon	nons I	Islan	d Rd.	Edg	ewater,	MD 2103	37
	Physician /Medical Examiner		23a. Part1. Enter the disease, or composition shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. E Sun Due to (d as	ine.		Cav		g, such as	cardiac or	respiratory a	rrest,		Approximat Interval Bet Onset and I	ween
8760,	cate be executed ohysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												
O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			□Ectopic pregnancy □ Other (specify)					23d. Date of delivery Month Day Ye				
ds, P	uires that signed b ild be deta	þ	Part II. Other significant conditions of	ontributing to death t	out not res	sulting in the	underlying	cause give	en in Part I.			obacco Yes 2	use contribute to		leath?
I Records,		Completed									24a. Was auto perfo	an psy ormed?	death?	topsy findings a completion of ca	available ause of
Vital	iician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	one)			
	Physic this c	ပ္	1 ☐ Yes 2 ☐ ₩0	Hospital: Inpati		ER/Outpati			4 🗀 Nu				6 ☐Other (Spec	eify)	
ב	nding Physician: th. After this certifica funeral director, p	lon:	27. Manner of Death 1 ■ Matural 5 □ Pending	28a. Date of Inju (Month, Da	iry iy Ye <i>ar)</i>	28b. Time Injury	,	28c. Injury Work			8d. Describe	how inju	ury occurred		
Division of	dea ctor the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		jury - At h tc. <i>(Speci</i>	ome, farm, : fy)	M street, facto		Yes 2 □ 1		8f. Location ( City or To		nd Number or Ru (e)	ral Route Num	ber,
	To the Hospitel or A within 24 hours after To the Funeral Directory filled in by	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best niner: On the basis of and manner st	of examina	owledge, de ation and/or	ath occurre investigation	d at the time	ie, date and pinion, deat	d place, a th occurre	nd due to the d at the time,	cause(: date ar	s) and manner as id place, and due	stated. to the cause(s	)
	To the To the Comp	ž	29b. Signature and title of certifier					9c. License					ate signed (Month		
			ym	MA			1	11417	6435	NIB	155	2,	113/04		
			30. Name and address of person who		death (Ite	m 23a) (Typ	e, Print)	140:11	ANN	1	BMIT	111	113/04 RE, MD	7175	) /
	Sta	te	31. Date filed (Month, Day, Year)	32. Segisti	rar's Signa	ature	01 10	1019	-81 816m	- / -	11011	100	5 100	0.00	
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DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

215 32. Registrar's Signature

			For	State of Ma	arylan		artment of h		and Me	ental Hyg	giene	200		
		_	- State Registrar			Ce	rtificate of	Death	1,	P. Date of Dea	Reg. No.	200		16574
	Physici		Decedent's Name (First, Middle, La		n ! I					Month	Day	Year		ime of Death
	/Medic Examin		Richard 4a. Fecility Name (If not institution, giv	James ve street and number)	P11	ke, S	4b. City, Town, o	or Location o		Februa		16,20 County of De		:20 a
ki	Examin	eı	210 Seagull Bea				Prince					Calve	ert	
	Funeral	A		Sex 7. Ag Ng M 2 ☐ F		ast birthday Yrs.	Months Days	If Under a	Min.	B. Date of Birtle (Month, Day Oct. 3,	Year)	9. B	irthplece (Sountry)	State or Foreign
li.	Director	-	218-34-4513 Usuel Residence of Decedent	<i>K</i>	65					JCL. 3,	1930		Mal	yland
	how		10a. State 10b. County			, Town or L								ide City Limits
	8a-fa	S	Maryland Calvert		Pr:	ince E	rederick				to- Chi-	en of What (		]Yes 2∏No
	with the or 2		10e. Street and Number 210 Seagull Bea	ich Road			10f. Zip Code	0678				.S.A.	Journay	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ahow fa Madical Examinar must be notified at	by Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Decedent of H		gin? (Spec	ify Yes or No-		4. Race - An		ian,
ဖွ	or Its	/Fur	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give	No		1 ☐ Yes 2 No		, rueno n	ican, etc.)		Black, Wh Specify:		
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pu	be filed tal Hygie d other event, II	Be	17. Father's Name (First, Middle, Last							First, Middle,	Maiden S	Sumame) Helms	-	
73	should be and Mental a marked of umatic ev	ဥ	Willard  19a. Informant's Name/Relationship	Pike	9	19b. Mai	ling Address (Street	Viol		Route Numbe	r, City or			)
Baltimore, Maryland 21215-0036	od 2 Ith a 27 li		Richard J. Pike,			1	Solomons 1							
ore,	ges 1 ar it of Hea if item or other		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □	Demoval from State	20b. P	lace of Disp emetery, cre	osition (Name of ematory or other pla	ce)	Da	te	20c. Loc	ation - City	or Town, St	ate
Ē	Pages Iment of Iant: If it jury or o		*4 ☐Donation 5 ☐ Other (Speci	ity)	Asl		emetery		2-21-	-04	Bars	tow, N	1D	
Ball	permit. Pag Department Important: I any injury o	7	21. Signature of Funeral Service Lice	The Mark	1		22. Name and Addre Rausch Fur			Р.А.,	Owi	nas. M	1D 20	736
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	d the death					<del> </del>		11957	Appro	oximate val Between
	Physician		Immediate Cause (Final disease or condition	y one gause on each			Infare	Hon						t and Death
	/Medical Examiner		resulting in death)	Due to for as			Cardre		1	2.	-			
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	uted 1 ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events											
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89 X	death certifica e attending ph od for use as th	Physiclan/Medl	IF FEMALE:	23c. If yes, outcome	of pregna	ıncy					2	3d. Date of d	elivery	
Box.	death a atter d for u	Iclar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			☐Ectopic pregnanc ☐ Other (specify) _	y				Month	Day	Year
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	Se un eq		Part II. Other significant conditions	- Ventre	1			ven in Part I.	•	T .	obaccous ′es 21s	e contribute }No 3□:		4 Unknown
of Vital Records	v requ	Completed by	itumorto esta	Vortico	010-1	/11	')			24a. Was				dings available
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ta	ician: Th certificate rector, pag	0	25. Was case referred to medical					26. Place	of Death	1 Yes (Check only o	2 <b>X</b> No ne)	1 41	35 2 1	
<b>1</b>	d in	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1  Inpati	ent 2	ER/Outpation	BUT 3 DOA			e 5 Resid			oecify)	
	ding P	ilon:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	ay Yeer)	28b. Time Injury	Wo	ryat ork? ]Yes 2. □		3d. Describe h	iow injury	occurred		
Division	Attending ir death. ector: After by the fune	ficat	2 Accident investigate 3 Suicide 6 Could not determine	be 28e. Place of In	jury - At h	ome, farm, s	street, factory, office			of. Location (S		Number or	Rural Rout	e Number,
Ö	s after al Dire	Certification:	4 Homicide	building, e	tc. (Specif	y) 				City or Tow	m, Siaie)			
	To the Hospitel or Attending Phwithin 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral	ledical	(Check only 2 Medical Exa	Physician: To the best	of examina									ause(s)
	thin 2 the I	Med	one) 29b. Signature and title of certifier	and manner st	tated.		29c. Licens	se number			29d. Date	signed (Mo	nth, Day, Y	(ear)
	To To		) Gerald	P. Sten	nes	mo	1	1172	145		Febr	rnave	118.	2004
			30. Name and address of person who	o completed cause of	death (Iten	n 23a) (Typi							<del></del>	
	IU		Gerald P. Ster	ner, M.D.	Cal	ert-A	rundel Me	dical	Cent	er, Ow	ings,	MD 2	0736	
	St Regist	ate rar	TEB 1	32. Regist	Seren	w St	South	P						
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Year **Physician** chary 3, 2004 01:59AM /Medical c. County of Death 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) Examiner If Under 24 Hrs. 8. pkins Johns orja If Under 1 Year 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) July 13, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 511-42-6609 58 Yrs. 1945 Director Kansas Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Meryland nent of Health and Mentel Hyglane. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊠Yes 2□No MD Director Dorchester Cambridge 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 412 Pleasant St. 21613 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 $^{\prime\prime}$ 1 ☐ Never Married 2 Married ŏ 1 X Yes 2 □ No Specify: Mexican Be Completed by Specify: hispanic 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) line worker electronics 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ie marked of Louis Tijerina Mary Lou Rodriguez 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth husband Jorge Perez 412 Pleasant St., Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of important: If it 1 Burial 2 ☐ Cremation 3 ☐ Removal from State East New Market Cemetery 2/6/04 Injury 4 Donetion 5 ☐ Other (Specify) East New Market, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner to (oxas a consequence of) Physician/Medical Examiner ettending physician and for use as the burial-transit or Attanding Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 05 Due to (or as a consequence of): within 24 hours efter deeth.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be deteched? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 XNo 3 Probably 4 Unknown ۾ 24b. Were autopsy findings available prior to completion of cause of death? Medical Certification: To Be Completed 24a. Wes an autopsy 1 🗌 Yes 2 XNO 1 🗆 Yes 21) 25. Wes case referred to medical 26. Place of Death (Check only one) examiner? 12 Inpatient 2000 1 Yes 2 ☐ ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Injury at Work? Maturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Brown, MD 8h.D. Lynette RES-000 3,2004 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Baltimore, Maryland 21287 Brown m North Street. Lynette 600 31. Date filed (Month, Dar. 1988)

Registrar **DHMH 16 Rev 6/95** 

State

05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** FEBRUARY 3, 2004 9:45 EDNA HELEN RYON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner STEVENSVILLE QUEEN ANNE'S 406 QUEEN ANNE'S CLUB DRIVE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (Stete or Foreign
Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Months **Funeral** 79 1 ☐ M 2 X F SEPT. 30, 1924 MARYLAND Director 219-12-2513 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show item 27 is marked other than "naturel", or Itams 23e or 28s-1 show other treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ▼ No Director QUEEN ANNE'S STEVENSVILLE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 406 QUEEN ANNE'S CLUB DRIVE 21666 USA death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? within 72 hours after Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. WHITE If Yes, Give Year or Dates: ð 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) is 1 and 2 should be filed within the Hallh and Mental Hygiene. BANKING 12 SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked to eny injury or other traumatic. LOUIS T. LOHMANN MILDRED LOOCK ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 953 SHADEWATER WAY, ANNAPOLIS, MD SANDRA REYNOLD/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State
4 Donation 5 Other (Specify) CHESAPEAKE CREMATORY 02/05/2004 STEVENSVILLE, MD 21. Sign wife of Funeral Service Licensee 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL 106 SHAMROCK RD., CHESTER, MD 21619 HOME, P.A. hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cays se on each line Immediate Cause (Final disease or condition resulting in death) the Cervix month **Physician** greinonza /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transit certificate be executed Due to (or as a consequence of): 68760 Physician/Medical the attending Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No detached for 5 ☐ Other (specify) 4 Pregnant at time of death P.0. 9 Unknown 9 🗌 Unknown ģ 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 1 Yes 2/12 No Division of Vital Be 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ٩ After this 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: or Attending 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a
To the Funeral C
completely filled i Hospital time, date and place, and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ŝ 20c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 00

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

pleted cause of death (Item 23a) (Type, Print) DAVID SMITH, MD, 29466 PINTAIL DRIVE, SUITE 5, EASTON, MD

31. Date filed (Month, Day, Year) FEB 0 9 200

State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month CHARLES 04 /Medical ebrupen 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WOSTINGON HAGERSTOWN 6. Sex 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia **Funeral** Months 1⊠M 2□ F Days 214-34-9708 66 Director June Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "naturel; or items 23e or 28e-f show ury or other traumatic event, it e Medical Examiner must be indiffed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14535 Marsh Pike 21742 USA Funerai 11. Marital Status Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married l □ Yes 2) No f Yes, Give 3altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: ≦ 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator 10 Fence Installation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Charles Washington Rankin Ella Elizabeth Howell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as important: If item 27 is any injury or other trau Doris L. Rankin/Wlfe 14535 Marsh Pike Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-7-04 | Clear Spring, Maryland Rose Hill Cemetery 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Funeral Service Licens 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of): Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours afferdeath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-transli Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 Probably 2 Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 1 Tyes No. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 2 No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. escribe how injury occurred 5 Pending investigation 2 Accident 1 Yes 2 No 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Example 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSESTOWN 510 IIIO Mesicol COMOUS egistrar's Signatur

DHMH 16 Rev 6/95

State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 2004 Smith Rawlings **Physician** Ashby February 15 2230 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Aug. 6, 1915 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Maryland X□XM 2□F Yrs. 577-38-7206 88 Director Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a, State 10b. County 28e-f show in then "natural", or Itams 23a or 28e-f show the Medical Evanting must be notified at 1 ☐ Yes 2 X No Directo Owings Maryland Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20736 USA 1535 Fowler Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status within 72 hours after 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐XNo Specity: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming . Pages 1 and 2 should be filed v frment of Health and Mental Hygien tant: If itam 27 Is marked othar ti jury or other traumatic evant, In 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rawlings Sarah Morsell Ashby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owings, MD 20736 Mildred Stubbs/Daughter 1655 Fowler Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Vaurial 2 □ Cremation 3 □ Removal from State permit. Page.
Department o
Important: If i
any injury or St. Edmonds UMC 2/21/2004 Chesapeake Beach, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 21. Signature of Funeral Service Licensee Glady a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Physician monts /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the ca Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical the use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy Day Month Year ö in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death signed by the at id be detached fo 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use confribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Se13 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown re mia peeu 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 1 Yes 2 PNo certificate 1 ☐ Yes 2₽No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 Ne N□Impatient ို 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this : After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2/16/04 36969 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUSBY MD 20657 TRVEMANRO SCARIA MATHEW MD 11910 HIG 31. Date filed (Month, Day, Year) 32. Registras Signature State EB 18 2004 Registrar

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			Decedent's Name (First, Middle, Last)					2. Date of Dea	ith	3. Time of Death
	Physicia /Medic		Elaine Randall					Februa	Day Yee	M
	Examin		4a. Fecility Name (If not institution, give s	street and number)		4b. City, Town,	or Location of Dea	th	4c. County of D	eeth
H			Anne Arundel Med	lical Cente		Annapo	lis		Anne A	rundel
	Funeral		5. Social Security Number 6. Sex	M 2187 F	s. last birthday) Yrs.	If Under †Year Months Days		. (Month, Dey	7, Year) 9.1	Birthplace (State or Foreign Country)
	Director		216-44-9186 Usual Residence of Decedent	57				Nov. 25	0 1946 M	aryland
	nyland thow		10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
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Maryland 21215-0036	within 72 hours after ene. than "natural", or Ita he Wedical Exemire	Completed	15. Decedent's Educ (Specify only highest grade	cation s completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	orking	16b. Kind of Busine	ss/Industry
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ğ	e filed I Hyg other	BeC	17. Father's Name (First, Middle, Last)	U	erb ne	sk Clei		me (First, Middle,	Maiden Surname)	
<u>Jar</u>	Mental Mental arked o	일	George Randa	11			Emmas	see Bill	liuns	
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Jor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Health and Health and Health and Indianal Exemples. Department of the modified at Angles.		16 Burial 2 ☐ Cremation 3 ☐ Re		cemetery, crei	matory or other pla Memori	ial	20.0	200. Education - Oily	or rown, State
altimore,	nit. P artme ortan injury	. 15	* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	Pa	rk	2. Name and Addr	2/	18/04 7	lnnapoli	s, Md. 2149
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	2		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea		ter the mode of dy	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between
	Physician	i n	Immediate Cause (Final disease or condition	Suda	(en	Cardi	ac D	eall		Onset and Death
48.7	/Medical Examiner		resulting in death)	Due to (b) as a conse	equatica oi).					
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<u> </u>		Con						perform 1 🗆 Yes		? es 2 No
<u> </u>	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	Tenie		har	ath (Check only on		
o	Attending Physician: r death. ector: Alter this certific by the funeral director.	H- 1	27. Manner of Death	1 ☐ Inpatient 2 €	28b. Time o	11 3L DOX	4 🗀 Nursing i	T	ence 6 Other (S ow injury occurred	Decity)
ion	ath. rr: Afte	atio	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yeer)	Injury		rk? ]Yes 2 □No			
Division of Vital Records,	i or Atte after de Directo d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (St City or Town	treet and Number or n, State)	Rural Route Number,
	urs af urs af eral D			<u> </u>						
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: Aller th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occ	e, and due to the coursed at the time, d	ause(s) and manner late and place, and c	as stated. ue to the cause(s)
	ro the	Me	29b. Signature and title of certifier	1		29c. Licen	se number	2	9d. Date signed (Mo	onth, Day, Year)
)			1 They	P.O.		114	7494		2/12/	04
			30. Name and address of person who con							
	-0		31. Date filed (Month, Day, Year)	32. Segistrar's Sign		175 /	ANNA	Pecis,	Mp.	21403
	Sta Registr		FEB 1 8 200		N 6	and a				

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registra 06580 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MELVIN WEBSTER SMITH FEBRUARY 9, 2004 9:51 A<sup>M</sup> /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 8. Date of Birth (Month, Day, TAN. 3, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 215-14-5176 1**∑**M 2□F Months 83 Director MARYLAND 1921 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event. The Madical Examiner must be notified at 10d. Inside City Limits Funerai Directo 1 Yes 2 No MD QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 GROLLMAN ROAD 21666 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 Syes 2 No 1942-If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian filed within 72 hours after Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Completed by Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 WATERMAN FISHING 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file timent of Health and Mental Hitant: If Item 27 is marked out 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH SMITH VERNA HIGDON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH SMITH/WIFE 401 GROLLMAN RD., STEVENSVILLE, MD 21666 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCremation 3 ☐ Removal from State injury or Department of Important: If any injury or CHESAPEAKE CREMATORY 02/12/2004 ¹ 4 □ Donation 5 □ Other (Specify) STEVENSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK RD., CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** wall /Medical Examiner WW Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dua to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) P.0. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has autopsy performe 1 ☐ Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 2DNo 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide þ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Dey, Year) 101 04 laryland Primary Care Physicians address of person who completed cause of death (Item 23a) (Type, Print) 1509 Ritchio Hwy Intonia " Amold, MD 21012 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

			For State Registrar	State	of Mar	yland / D	epa <i>Cer</i> t	rtment of H tificate of L	ealth and I Death	Mental Hy	giene 2	004	06581
			1. Decedent's Name (First, Middle, La							2. Date of De		Year	3. Time of Death
	Physici /Medic		Sheila Ma	rion Sa	yles					Februar		2004	10:45pм
	Examin		4a. Facility Name (If not institution, giv	e street and nu	ımber)			4b. City, Town, or	Location of Deatl	h	4c. Cc	ounty of Death	ı
			106 Bryan Place					Hagers	town		V	Jashing	ton
	Funeral		5. Social Security Number 6. S	ex □ M 2 <b>X</b> 1F	7. Age (	'In yrs. last birti		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di	rth	9. Birth	place (State or Foreign
	Director		212-38-9833	□ M 2ΔJF		80 )	rs.	Months Days	, todio	Sept. 2	20,192		ndon
	pu .		Usual Residence of Decedent  10a. State 10b. County		1	0c. City, Town	orloc	ation					10d. Inside City Limits
	aryia sho	5											1X Yes 2 □ No
	Ba-f	Director	Maryland Washing	ton		Hager	stor			[		///	
	with t		10e. Street and Number					10f. Zip Code				of What Cou	intry?
	s 23	Funerai	106 Bryan Place	12. Was Dec	adast Cu	or in II C	12 14	21740	nania Orinina (C	nasihi Van es Ni	USA	Race - Ameri	iona Indian
	ltem Item	Ë	11. Marital Status 1 ☐ Never Married 2 🕅 Married	Armed F	orces?	er in U.S.	IS. W	as Decedent of His Yes, specify Cubar	n, Mexican, Puert	o Rican, etc.)	]-	Black, White	
35	Ir, or	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, G	ive		1	☐ Yes 2💢 No	Specify:		Sp	ecity: Wh:	ite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23e or 28e-f show ent, the Medical Evaninar must be notified at	ed	15. Decedent's E	ducation		16a.	Decede	ent's Usual Occupa	ition		16b. Kind	of Business/Ir	ndustry
ر د	In 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)		1-4or 5+)		(Give k life. D	ind of work done d O NOT use retired)	uring most of wor	rking			•
77	r tha	E	10	College	1-401 5+/	Sto	ore	Clerk			Hay'	s Stat:	ionarv
פַ	othe /ent,	Be C	17. Father's Name (First, Middle, Last,		-				18. Mother's Nar	ne (First, Middle			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. item 27 Is marked other than "natural", or items 23e or 28e-f show item 27 Is marked other than "natural", or items 23e or 28e-f show othar traumatic avent, the Ms.deal Evantifier must be notified at	To E	Joseph Whittle						Adelade	e Whittl	.e		
a S	should A and A sund A ma	10 8	19a. Informant's Name/Relationship (	Туре, Print)		19b.	Mailing	Address (Street a	nd Number or Ru	ıral Route Numb	er, City or To	own, State, Zij	p Code)
Σ	1 and 2 Health a tem 27 is		William H. Sayles	s /Husb	and	10	)6 В	ryan Plac	ce, Hage	rstown,	Md.	21740	
ē.	item	1	20a. Method of Disposition			20b. Place of cemeters	Dispos	ition (Name of atory or other place	9)	Date	20c. Locat	ion - City or T	own, State
Ĕ	Page nent c int: If		1 🖾 Burial 2 □ Cremation 3 □  `4 □ Donation 5 □ Other (Specil		State			n Cemete	II	/2004	Hager	stown,	Maryland
altimore,	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other ORCS.		21. Sign fur of Funeral Service Lices	1500			22.	Name and Address	s of Facility Re	st Have			
ñ	Par in S		X, 7/1	_									Md. 21742
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that	caused th	e death. Do n	ot ente	r the mode of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	/		arre.	2	Carcin	nona				Onset and Death
	/Medical		resulting in death)	a. Due to	(or as a c	consequence o		-					1 dear
	Examiner		Commentally that are distant	<b>b</b>									
	_ +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a c	onsequence o	i):					- 1	
	cutec	Examiner	Cause (Disease or injury that initiated events	c									
Š	e exe ian a urial-		resulting in death) Last	Due to	(or as a c	consequence o	if):					Ţ	
8/60,	icate be executed physician and s the burial-transit	dicai		_ d								-	
9	ing p	Mec	IF FEMALE:						-				
XOR	death certifi e attending id for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		birth 2	Fetal death		Ectopic pregnancy			23d	. Date of deliv Month	ery Day Year
	0 0 2	sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Preg 9□Unkr		ne of death	5 🗆	Other (specify)				WOITH	Day Tour
Ţ.	law requires that the de: as been signed by the a 2 should be detached fi	Phy	Part II. Other significant conditions of	antributing to a	danth but	ant requiting in		dashina sawas awa	a ia Dani I	230 Did	obassa usa	aantributa ta t	he cause of death?
Š,	res ti signe		Faith: Other significant conditions	ontributing to C		H an	LITE ONC	Jenying cause give	nın raili.	1 🗆		And the second second	bably 4 Unknown
5	w require been sig should b	ed		<del>~~~</del>	10	10-9		*vzcc					
Hecords,	afaw nasb e 2 sl	Completed								24a. Was auto	osv 🗸	prior to co	ppsy findings available empletion of cause of
	an: The faw rtificate has for, page 2 t	ပ္ပ								1 ☐ Yes	rrmed? 2⊡No	death? 1 ☐ Yes	2 ☐ No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		,		Oth -	26. Place of Dea	th (Check only o	one)		
	Physical this call dir	2	1 Yes 2 No		Inpatient				4   Nursing H	ome 5 Resi			fy)
ב	Viter	ō	27. Manner of Death 1 ☐ Natural 5 ☐ Pending		of Injury oth, Day Y	(ea <i>r</i> ) 28b. Ti	ime of jury	28c. Injury Work	?	28d. Describe	now injury or	ccurred	
<u>s</u>	tend death tor:	icat	2 Accident investigation 3 Suicide 6 Could not b		of laine	At home for			es 2 □ No	204 Leastine (	Ctropt and M	umbar ar Our	nt Claute Mumbar
DIVISION OF	or A	Certification:	4 Homicide determined	build	ling, etc. (	Specify)	m, stree	et, factory, office		City or To		umber or Aure	al Route Number,
_	pital ours a leral filled		29a. Certifier 1 Certifying Pt	Vsician: To th	a heet of	ny knowledge	death	occurred at the time	a date and place	and due to the	cause/s) s=	d mannor on	tated
	24 h	Medical	(Check only 2 Medical Examone)	niner: On the t	asis of ex	camination and	Vor inve	estigation, in my op	inion, death occu	rred at the time,	date and pla	ice, and due to	o the cause(s)
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: / completely filled in by the fi	Me	29b. Signature and title of certifier	1	1	_		29c. License	number		29d. Date si	gned (Month,	Day, Year)
,	- s - ō		h	, (	X	1 / 1	Λ	177	5 < 1		Ta 1 -		7 252114
	3		30. Name and address of person who	completed cau	se of deat	th (Item 23a) (1	Typa P	rint)	000>		1000	20,21	1,000
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Ĭ	Sta	te	31. Date filed (Month Day Year)	32.1	Registrar's	Signature			3	11	410	/	
	Registr	ar	LED I O	2004	Soule in	J.	M	ene					

		-	For State Registrar		State	of Mar	yland / De <i>C</i>	partmen e <i>rtificate</i>	t of H e of L	ealth a Death	and M	lental Hy	giene A	2004	06582
			1. Decedent's Name (F	First, Middle, L.	ast)							2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medic		Marce	ella	Fi	sk	Sund	erlan	d			Februa	ry 13	2004	5:58 p M
	Examin		4a. Facility Name (If no	ot institution, gi	ve street and	number)		4b. City,	Town, or	Location of	of Death		4c. C	ounty of Death	
			Calvert M	emoria]	l Hosp	ital		Pri	.nce	Frede				alvert	
	Funeral Director		5. Social Security Num 579–50–17		Sex 1 □ M 2 🔀		In yrs. last birthda Yrs	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Do Aug 16	rth ey, <i>Yeer)</i> , 193	Cou	place (State or Foreign ntry)
	9		Usual Residence of De				0- Oit T-	1							10d Inside City timbe
	show	_		0b. County		1	0c. City, Town or		_						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8e-f.	5		Calvert					Owir	igs					
	ith th	Funeral Director	10e. Street and Number					10f. Zip						n of What Cou	ntry?
	ath v	ra	7230 Sout	hern Ma				2 Was Dasse	2073		i=i=2 /C==	- Was as No		USA . Race - Ameri	can Indian
	er de	ne	11. Marital Status	O Massias	Arme	Decedent Eve d Forces?	er in U.S. 1	If Yes, spec	erty Cuba	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	0-   14	Black, White,	
36	rs aft	by F	1 ☐ Never Married 3 ☑ Widowed 4 [		If Yes	es 2⊠No , Give or Dates:		1 ☐ Yes	2 <b>X)</b> No	Specify:			S	pecify: Wh	nite
21215-0036	72 hours after death with the Maryland natural: or Items 23a or 28e-f show Jical Examanar must be notified at	ed		5. Decedent's f		0. 54.00.	16a. De	cedent's Usua	al Occupa	ation			16b. Kind	l of Business/Ir	dustry
15	in 72 n "n	plet		only highest g	rade complet		(G iife	ve kind of wo	rk done d se retired	during mos I)	t of worki	ng			,
212	d within jiene. r than "	Completed	Elementary/Seconda	ary (0-12)		ge (1-4or 5+) 2	boo	kkeepe	er				tax	prepar	ation
	e filec Hyg othe ent,		17. Father's Name (Fir	rst, Middle, Las	t)					18. Mothe	er's Name	(First, Middle	, Maiden Si	umame)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene it health and Mental Hygiene it with 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at	To Be	Bert 19a. Informant's Name	o/Bolationship		Fisk	105 M	ilina Address	/Street	Dor:		Aureli		eeks <sup>r</sup> own, State, Zij	a Code)
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o î	1 and 2 Health tem 27 to	. 3	20a, Method of Dispos		JET TAIL		20b. Place of Dis	position (Nan	ne of			ate		tion - City or T	
Ď	at of I		1 ⊠ Burial 2 □ 0	Cremation 3	□Removal fo		cemetery, o	rematory or o	ther plac		2 17	2002			
Baltimore,	t. Pa rtmer rtent njury		*4 □Donation 5   21. Signature of Fuger				Mt. Har	MONY C 22. Name an		-		-2003	OWII	ngs, MD	20736
Bal	permit. Pages Department of h Importent: If ite any injury or of		> /NOC	om R	9k	-					20000	ne, P.A	., Ow	ings, M	D 20736
			23a. Part1. Enter the shock, or heart fa	disease, or cor ailure. List onl	mplications they one cause	nat caused th on each line.	e death. Do not	enter the mod	e of dyin	g, such as	cardiac c	or respiratory a	irrest,		Approximate Interval Between
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	Examiner		Sequentially list condi-	itions.	b										
	sit od	Examiner	Sequentially list condi- if any, leading to imme cause. Enter Underlyi Cause (Disease or inju-	ediate ing	Due	e to (or as a d	onsequence of):								
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8760,	ate t	edical		•	d						-				
9 ×	leath certificate be execut attending physician and I for use as the burial-trar	/Me	IF FEMALE:		23c If yes	, outcome of	pregnancy							4 Para at dall	
Вох	death c	Physician/M	23b. Was decedent pr in the past 12 mg		1 🗆 L		Fetal death	3 DEctopic pr					23	<ul> <li>d. Date of deliv</li> <li>Month</li> </ul>	ery Day Year
P.O.	0 0 0	ysic	1 ☐ Yes 2 ☑ N 9 ☐ Unknown	10		nknown	10 Of Geath	5 🗌 Other (sp	ecity)						
	requires that the een signed by th nould be detache		Part II. Other significe	ent conditions	contributina	to death but i	not resulting in the	underlyina c	ause give	en in Part I		23e. Did	tobacco use	contribute to t	he cause of death?
ds,	8 50	d b	Cordina	Arrhy	thmi	ns.		, ,				10	Yes 2 🗹	No 3 □ Proi	bably 4 Dunknown
Division of Vital Records,		Completed by	Olon				0-100	11-1	- 1	1		040 1450		Odb. More out	and findings available
Sec.	a SC	Ju	Pleural	600	LSTON	2	Perica	10/01	-6/	Dung	$bn_{,}$	24a. Was	psy ormed?	prior to co death?	opsy findings available impletion of cause of
=	ate pag	S	Pneun	10 Nic	Ρ.,							1 ☐ Yes	2 1 No	1 ☐ Yes	2□ No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred examiner?		Hospital:				Othe	20		(Check only			
of	phys this al dir	၉	1 Yes 2 No	)		1 Impatient	2 ER/Outpa		/A	4 LINU		me 5 Res 28d. Describe		Other (Special	(y)
Ē	ding P	on		5 Pending		Date of Injury Month, Day Y	'ear) 285. Time	y M	8c. Injury Work	γαι ∢? Yes 2		zau. Describe	now injury (	occurred	
Sic	ttend death tor: the	cat	2 ☐ Accident 3 ☐ Suicide	investigati 6 ☐ Could not	be con c	Place of Injuni	- At home, farm,					28f Location	Street and I	Number or Rus	al Route Number,
N N	or A offer of Direction by	Certification:	4 🗆 Homicide	determine	d 200. F	uilding, etc. (	Specify)	Sileet, factory	, once		'		wn, State)	vanibor or riar	ar riodio realiber,
	pitel ours a erel (	ပိ	29a. Certifier 1[	* Cartifuina E	Physician: T	o the best of	ny knowledge, de	ath conumed	at the tim	no date ar	nd place i	and due to the	021100(0) 20	nd manner as s	tated
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	edicai			eminer: On the		camination and/o								
	thin the other	Me	29b. Signature and titl	le of certifier		^	-	290	. License	e number			29d. Date :	signed (Month,	Dey, Year)
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	12		30. Name and address	Deale	· cia	unchta		ocid -	377	Dea		ンリスト	D.	2075	1.
	JØ∖ Sta	to	31. Date filed (Month,	Day, Year)	3	32. Registr	s Signature			VEL	/	///	62.	010	ı
	Regist			FEB 1	8 200	4) 80	Signature	April	Was.						

			For State Registrar	State of	Marylan	•	artment of H			giene Reg. No. 200	4 06583
			1. Decedent's Name (First, Middle, L	ast)					2. Date of Dea Month	ith	3. Time of Death
	Physicia	_	Ethel Ward St	<sub>7</sub> วกท						v 13, 200	
	/Medic Examin		4a. Facility Name (If not institution, g		ber)		4b. City, Town, or	Location of Death		4c. County of Di	
	<u> </u>		7744 Swan Lane				Owings			Calvert	County
	Funeral				. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey		Birthplece (State or Foreign Country)
П	Director		213-42-7425	1□M 2\F	92	Yrs.	Months Days	Hours Will.		10. 1911	Maryland
-	<b>D</b> .		Usuel Residence of Decedent						•		
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 💆 No
	Ba-f e	cto	MD Calvert	County	Owi	ngs					
	ith th	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
	23a		7744 Swan Lane				20736			U.S.A.	
	leme leme	Funeral	11. Marital Status	12. Was Deced	es?	.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S <sub>i</sub> ın, Mexican, Pu <i>er</i> ti	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	or It	<b>by</b> Fi	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	,		1 ☐ Yes 2 💢 No	Specify:		Specify: V	hite
Ö	d within 72 hours after death with the Marylend jene. Ir than "natural", or Itema 23e or 28e-f ehow the Madrial Examiner must be notified at	d b	3 XWidowed 4 □ Divorced	Year or Da	105:	160 Dage	dontin Havel Occur.	ation		16b. Kind of Busine	an findustry
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2	Hygi ther int, I		17. Father's Name (First, Middle, La	st)		1 IIOI	enaker	18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
an	d d d	o Be	Benjamin Ward					Mami e	Hardesty	J	
Maryland 21215-0036	2 should be and Mental le marked eumatic ev	၉	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a			r, City or Town, State	a, Zip Code)
∑ S			J. Allen Swann	(Son)		7742	Swan Lane	e, Owings	, Maryla	and 20736	
ō,	ss 1 and 2 should of Health and Men (Item 27 le marke rother treumatic		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of natory or other plac	Fohm	lary 16,	20c. Location - City	or Town, State
<u>ō</u>			1  Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		(ate		matory or other place Mem. Gard		10, 10, 10, 10, 10, 10, 10, 10, 10, 10,	Dunkirk,	Maryland
Baltimore,	artme ortan injury		21. Signature of Function of		BUL						lvert, P.A.
Ba	permit. Page Department of Important: If any injury or once.		Michael W	Lee							, MD 20736
			23a. Pert1. Enter the disease, or co shock, or heart failure. List on	mplications that ca y one cause on ea	used the deat ch line.	h. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory are	rest,	Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition	а	Seps	515	Sund	ome			Onset and Death
	/Medical Examiner		resulting in death)	Due to (c	r as a consec	uence of):	1 4				
и	Cxammer		Sequentially list conditions,	b	Hdu	avce	1 Age				
	sit ad	line	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c	ras a consec	Juence or):	V)				3
	and I-tran	Examine	that initiated events resulting in death) Last	c	r as a consec	ulence of):					
8760,	death certificate be executed attending physicien and e attending physicien and of for use as the burial-transit				. 40 4 00000	1001100 017					
87	cate physic	dlcal		d							
9 x	death certific attending pl	Physiclan/Me	IF FEMALE:	23c. If yes, outc	ome of orean	ancv				23d. Date of	dolaron
Вох	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 ☐ Feta nt at time of c	ıl death 3 [	Ectopic pregnancy Other (specify)			Month	Day Year
o.	at the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknor		,6um 0_					
<b>Q</b>	The law requires that the tite has been signed by the bage 2 should be detache		Part II. Other significant conditions	contributing to dea	ath but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds,	sign d be	d by							1 🗆 Y	es 202 No 3	Probably 4 Unknown
Vital Record	een s	ompleted							24a. Was a	an 24h Wara	autopsy findings available
300	has has	ldm							autop perfor	sy prior	to completion of cause of
al		O							1 ☐ Yes	26.No 1 1 Y	es 2 No
Ž	Physician: 'this certifica'ral director, p	Be	25. Was case referred to medical examiner?	Hospital:			Oth	00	th (Check only or		
o	Phys this ral dir	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 🗆 In		ER/Outpatier 28b. Time of	T 3L DOA	4   Nursing H		lence 6 Other (S	pecify)
L	ling After fune	lon	1 Danuard 5 ☐ Pending	28a. Date o (Month	, Day Yeer)	Injury	Wor	k? Yes 2 □ No	200. 00001100 11	injury cocurred	
Si	r Attending er death. rector; After by the fune	Ica	3 ☐ Suicide 6 ☐ Could no	be 380 Place	of Injury - At h	ome farm str	eet, factory, office		28f. Location (S	itreet and Number or	Rural Route Number.
Division	Diagram	Certification:	4 Homicide determine	buildin	g, etc. (Speci	fy)	oot, radiory, orrivo		City or Tow		
	e Hospitei 24 hours a e Funerel C		29a. Certifier Certifying	Physician: To the	best of my kno	owledge, deat	h occurred at the time	ne, date and place	, and due to the o	cause(s) and manner	as stated.
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medicel Ex	eminer: On the ba and mann	sis of examina er stated.	ation and/or in	vestigation, in my o	pinion, death occu	rred at the time, o	date and place, and o	lue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	11	5)		29c. Licens	e number	, 1	29d. Date signed (Mo	onth, Dey, Year)
				/ //	//		0	33123	5	February	13, 2004
			30. Name and address of person wh	o completed cause							
	5		Jonathan D. Low				spital Roa	ad, Princ	e Freder	rick, Mary	land 20678
	Sta		31. Date filed (Month, Day, Year)		gistra/s Sign	ature	1				
	Registi	ar	FEB	1 7 2p04	J.	1 15	Course				

			For State Registrar	State of Marylan	d / Depa	artment of I	Health and Death		giene2001	06584
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of De Month	Day Yee	
	/Medic	al	Harley Elvin Sm  4a. Aacility Name (If not institution, give	<i>'</i>		4h City Town	or Location of Dea	rebruar	4c. County of De	
	Examir	er	Keninswa Regiona	1 60 1 . 1	nkz	Solis	bury		Wicin	
	Funeral Director		5. Social Security Number 6. Se			If Under 1 Year Months Days			y, Year) (	irthplace (State or Foreign Country) EW Jersev
	and		Usuel Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
_	Maryl -f ehc	tor	Maryland Dorches	tor	Cambr	idaa				1 ☐ Yes 2 No
ζ	th the	lrec	10e. Street and Number	LEI	Campl.	10f. Zip Code			10g. Citizen of Whal	Country?
ζ	ath wil	ralD	1305 Broadview Dr	ive			613		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23s or 28s-f show any njury or other traumatic event, the Medical Examinar must be notified at ADES.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 (35) es 2 No 1/Yes, Give Year or Dates: WW		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2000 No		Specify Yes or No rto Rican, etc.)	Specify: _	
21215-0036	2 hour	ted t	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Busines	Vhite s/Industry
215	en "n	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo ed)	orking		
7	filed with Hygiene other the		12	2	Tax	Assesso		(F)	Town Gos	zernment
and	ntal H ntal H ed ott	Be	17. Father's Name (First, Middle, Last)	+h Cm					Maiden Sumame)	
Maryland	2 should be and Mental ie marked c	70	Harley Elvin Smi 19a. Informant's Name/Relationship (7)		19b. Mailir	ng Address (Stree		Von Berg	zen er, City or Town, State,	Zip Code)
	i and 2: Health ar em 27 ie		Nancy E. DeLozier	/Daughter	312	6 Cinnam	on Lane,	Linkwood	d, MD 2183	35
Baltimore,	of Hei		20a. Method of Disposition  1  Burial 2 Cremation 3  F	20b. F	lace of Dispo	sition (Name of natory or other pla	100)	Date	20c. Location - City of	r Town, State
Ē	Pages Iment of tant: If it jury or o		* 4 □ Donation 5 □ Other (Specify)	Mic						e, Maryland
Bail	permit. Page Department of Important: If any njury or		21. So fure at Funeral Softvice Licens  (author) There's a	a James					ome, P.A. D 21613	
	Physician		23a Part Enter the disease, or composhock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused the deather cause on each line.				ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conseq	uencelof):		1			0.0.73
'n.	LXammer	-	Sequentially list conditions, if any, reading to immediate	Due to for as a consen	arte	ry disea	ise			year
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			1.				411
,092	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):					
687	physicate s the l	edical		d						
.O. Box (	The law requires that the death certificate be executed to has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, oulcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	Ectopic pregnand Other (specify)	y .		23d. Date of d Month	elivery Day Year
۵.	hat th ad by I	Phy	Part II. Other significant conditions co.	ntributing to death but not res	ulting in the u	nderlying cause g	ven in Part I	23e. Did to	obacco use contribute	to the cause of death?
ords,	w requires been signe should be	ted by								Probably 4 Unknown
Division of Vital Records,		Completed						24a. Was autop perfo 1 Yes	rmed? prior to	autopsy findings available completion of cause of
/ita	ician: The certificate ector, pag	Be	25. Was case referred to medical examiner?	Jognital:				eath (Check only o	ne)	
o	Physic this cral dir	. To	1 Yes 2 No	lospital: 1 Inpatient 2 2	ER/Outpatier 28b. Time of	I 3 DOA			dence 6 Other (Sp	ecify)
lon	Attending Physician: r death. ector: After this certifics by the funeral director.	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yeer)	Injury	Wo	rk? ]Yes 2 □No	200. 06301100 1	iow injury occurred	
Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al ho building, etc. (Specify	ome, larm, str v)	eet, factory, office		28f. Location (S City or Tox	Street and Number or F vn, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in I	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	occurred at the treestigation, in my	me, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and manner a date and place, and du	is stated. le to the cause(s)
	To the within To the	W	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Mor	oth, Day, Year)
•			> Stephala	- mp		DY	1721		02/06/04	
			30. Name and address of person who co				60,000	(4 )A = 7	m > 5/ h 1/	
	Sta	te	STEPHNU PAVIOS 31. Date filed (Month, Day, Year)	32 Begistrar's figna	.SHORE	DI-	SALISBUR	y mo	21804	
	Registr		FEB	I U ZUNA	wer L	F (2004)				

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State of Maryland / Department of Health and Mental Hygiene	2004

December News Pirit Modes (Latif)    Comment		1 - For State Registrer	ate of Maryland / Depa <i>Cei</i>	artment of Health and I rtificate of Death	Mental Hygiene Reg. No.	2004 06585
Examiner  Examin		Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
Examiner  # Feith Part   Principles   Princi		GEORGE RAYMOND SANDY				
Social Service Number    23-440-90.32   \$\frac{1}{2}  will be produced by the control of t	- Carlotte	4a. Fecility Name (If not institution, give street				
Director    Control   Property   Control   Property						
The State   100. County   100.		213-40-9032 <sup>1</sup> X <sup>M 2</sup>			(Month, Day, Year)	Country)
The set of position	land bw		10c. City, Town or Lo	cation		10d. Inside City Limits
The state of the	Many He she	Maryland St Mary's	Mechani	csville		1 A Yes 2 □ No
The state of the	sa or 284	10e. Street and Number 27276 Sandy Acres		'	10g. Citi	
Physician / Modical Examiner of June 10 (or as a consequence of):  Sequentially list conditions as a consequence of):  Due to (or as a consequ	irs after death		med Forces? □ □Yes 2 X No /es, Give	f Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.
Physician   Militer PRs. Id.   Militer Prs.   Ma.   Militer Prs.   Militer Prs.   Ma.   Militer Prs.   Militer Prs.   Ma.   Militer Prs.	within 72 hound ne. Then "neture E Workel E		pleted) 16a. Deced (Give life. L	kind of work done during most of wor DO NOT use retired)	king	
23a. P. M. Frether the disease, or complications that caused the death. Do not enter the mode glidying, such as cardiact or respiratory afrest.    Implicate Cause (Final Implication Cause) (Final Implication Cause (Final Implication Cause) (Final Implication	Hygie ther the nt.		DIS			
Physician   Militer PRs. Id.   Militer Prs.   Ma.   Militer Prs.   Militer Prs.   Ma.   Militer Prs.   Militer Prs.   Ma.   Militer Prs.	Mental Mental Marked of	Tarada Garaga			,	,
Physician   Militer PRs. Id.   Militer Prs.   Ma.   Militer Prs.   Militer Prs.   Ma.   Militer Prs.   Militer Prs.   Ma.   Militer Prs.	2 sho					
Physician   Militer PRs. Id.   Militer Prs.   Ma.   Militer Prs.   Militer Prs.   Ma.   Militer Prs.   Militer Prs.   Ma.   Militer Prs.	Pages 1 and ent of Health ht: If Item 27 y or other t	20a. Method of Disposition 1 ☐ Buria 2 2 Cremation 3 ☐ Remove	20b. Place of Dispo	sition (Name of natory or other place)	Date 20c. Lo	cation - City or Town, State
Importance Cause (Final disease or condition resulting in death)   Due to (or as a consequence of)	permil. F Departm Importar any njun	11 11	M00173 22	Name and Address of Facility Ebe	erwein Funer White Pls.	al Services , MD 20695
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   Residence   6   Other (Specify)    27. Manner of Death   1   Matural   5   Pending investigation   3   Suicide   4   Homicide   28a. Date of Injury   28b. Time of Injury   M   1   Yes   2   No    28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes   2   No    28b. Place of Death (Check only one)   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   Residence   6   Other (Specify)    28c. Injury at Work?   1   Yes   2   No    28d. Describe how injury occurred   1   Yes   2   No    28d. Describe how injury occurred   1   Yes   2   No    28d. Describe how injury occurred   28d. Descri	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Oue to (or as a confequence of):	re Casterio	2016	fice 10g1s
25. Was case referred to medical examiner?  1   Yes   2   No  27. Manner of Death  1   Alaural   5   Pending investigation  3   Suicide   4   Homicide  28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?  1   Yes   2   No  27. Manner of Death  28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?  1   Yes   2   No  28b. Time of Injury   28c. Injury at Work?  1   Yes   2   No  28c. Injury at Work?  1   Yes   2   No  28d. Describe how injury occurred  28d. Describe how injury occ	the death certifically the attending phiched for use as it		Live birth 2 Fetal death 3 Pregnant at time of death 5		2	*
25. Was case referred to medical examiner?  1   Yes   25   No   Hospital:   I   Inpatient   2   ER/Outpatient   3   DOA   Other:   28d. Describe how injury occurred   Work?   1   Yes   2   No   2   Accident   3   Suicide   4   Homicide   4   Homicide   4   Homicide   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number of Number	uires that signed b d be deta		ng to death but not resulting in the ur	nderlying cause given in Part I.		\$ 20
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	The law requares the cate has been page 2 shou				autopsy performed?	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	certifi ector	examiner?	ŀ	Other		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ing Phys After this uneral dir	TES 2000	Date of Injury 28b. Time of	28c. Injury at Work?		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	al or Attende safter death I Director: d in by the	2 Accident Investigation 3 Suicide 6 Could not be determined 28e	. Place of Injury - At home, farm, stre building, etc. (Specify)			l Number or Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Hospit 24 hours Funere etely fille		n the basis of examination and/or inv	occurred at the time, date and place estigation, in my opinion, death occur	, and due to the cause(s) arred at the time, date and	and manner as stated. place, and due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To the within To the compl	29b. Signature and title of certifier	Sent as	29c. License number	29d. Date	signed (Month, Day, Year)
Deen W. Berube, M.D. 28170 old village Bd. Machanian van	io	30. Name and address of person who complete	ed cause of death (Item 23a) (Type, I	Print)	loch-ni-	
Leon W. Berube, M.D. 28170 Old Village Rd. Mechanicsville, MD 2060  State 31. Date filed (Month, Day, Year) 32. Projectrar's Signature.	D C			viiiage ka. N	lechanicsv:	ille, MD 20609

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06586 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Harry Thomas February 8, 2004 10:00P M /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Avalon Manor Health Care Center Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth

About Days Hours Min. (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 ☐ F 214-28-7358 72 Sept. 19,1931 Maryland **Director** Usual Residence of Decedent item 27 is marked other than "naturel", or items 23a or 28a-1 show other traumatic event, the Modical Exercities invest be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9619 Morning Glory Lane 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status t XYes 2 No If Yes, Give Year or Dates: 1 XNever Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Gilbert Reno Thomas Mable Pauline Eyerly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard B. Thomas/Brother if item 27 541 Hanshew Lane Martinsburg, WV 25401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ŏ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department importent: if any injury or once. 2/11/2004 Rest Haven Cemetery Hagerstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rest Haven Funeral Chapel Ave. Hagerstown, MD 21742 Approximate Interval Between Onset and Death Physician Chroni disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** peimer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the burial-transit resulting in death) Last Due to (or as a consequence of): Be Completed by Physiclan/Medical use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s Jas 1 Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide tter certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

The law requires that the death certificate be executed

Box 68760.

P.0.

Division of Vital Records.

Hospitei or Attending Physicien:

Baltimore, Maryland 21215-0036

-SHED

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Un

ARID

31. Date filed (Month, Day, Year)

20060336

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		-	For State Registrar	State of Mary		artment of Hertificate of I		d Mental Hyg R	iene g. No. 201	04 06587
	15.4		1. Decedent's Name (First, Middle, Last	0				2. Date of Dear	h Day Ye	3. Time of Death
	Physicia /Medic		Margery Belle Tri					Februci	ry 9 20	04 10.34 M
	Examin	4	4a. Facility Name (If not institution, give			4b. City, Town, or		eath	4c. County of D	
.,*			Washington County 5. Social Security Number 6. Se		n yrs. last birthday	Hagersto	OWN If Under 24 I	Hrs. 8. Date of Birth		ton County  Birtholece (State or Foreign
	Funeral Director			M 2 <b>½</b> F	97 Yrs.	Months Days	Hours N	Win. (Month, Day) Sept. 18	,1906	Birthplece (State or Foreign Country) Pennsylvania
	ס		Usual Residence of Decedent		2- Ott. T					10d. Inside City Limits
	arylar show	٦	10a. State 10b. County		0c. City, Town or I					Y∰Yes 2 No
	Ne M	ectc	Maryland Washing	con	Hagerst	OWN 10f. Zip Code		1	0g. Citizen of What	Country?
	Sa or	ī	79 Sunbrook Lane			21742			U.S.A.	
	death ms 23	by Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13	. Was Decedent of H	ispanic Origin	? (Specify Yes or No- ruerto Rican, etc.)		American Indian, Vhite, etc.
ထ	or Ite	/Fui	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 No		delle i ficali, etc./	Specify:W	
Š	ure!',		3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Edi	Year or Dates:	16a Doo	edent's Usual Occup	nation		16b. Kind of Busine	
5	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28a-f show that the Medical Esandrat must be notified at	Completed	(Specify only highest grad	de completed)	(Giv	e kind of work done  DO NOT use retired	during most of	working	TOD. PRING OF DUSING	oog maasty
212	d with giene. rr ther	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Pra	ctical Nu	rse		Nursing	g Home
g	al Hyg	Be C	17. Father's Name (First, Middle, Last)					Name (First, Middle, i	Maiden Sumame)	
<u>yla</u>	should be nd Mental marked umatic ev	To	Lemuel Divens					Myers		
Mar	12 sh h and 7 le m traum		19a. Informant's Name/Relationship (T Jane D. Webb/Dau					r Rural Route Number Hagerstow		
e,	1 and Health		20a. Method of Disposition		20b. Place of Disa	position (Name of	Ţ	Date	20c. Location - City	or Town, State
nor	Pages nent of I nnt: If its ury or o		t Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Cedar La	wn Memoria	ål Park	Feb.13,04	Hagersto	own, Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturel; or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service Licen			22. Name and Addre	ss of Facility	Douglas A.	Fiery F	uneral Home
m	99 1 9		1 Decelar	V Juri				<i>r</i> d.N. Hager		aryland 21742
8760,	Physician and /Medical Examiner but still physician and physician still physician and	ai Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any localing to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	tal ur consequence of): tract wisequence of):	ospogs infectiv	· ru			Interval Batween Onset and Death
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Division of Vital Fecords,	ilcian: The law rex certificate has bee rector, page 2 show	Completed by	arteny disease,	asrtic Ja	loulande	reare, de	pliped	24a. Was a autops perform	y prior med? deat	e autopsy findings available to completion of cause of h? Yes 2 \sum No
ita	artifice ctor. p	BeC	25. Was case referred to medical examiner?					Death (Check only or	(9)	
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_	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C		ysician: To the best of r niner: On the basis of en and manner state	xamination and/or					
	To th To th comp	Me	29b. Signature and title of certifier	16		29c. Licens	40		9d. Date signed (M	
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les de	7,10		30. Name and address of person who were the common of the	confeleted cause of dea	th (Item 23a) (Typ Jorthan	e. Print) Aveny	e Ho	agerstoin	IC am	742
8	St	ate	31. Date filed (Month, Pan Year) 2 2	004 32. Registrar's	s Signature	Carels		V		

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Robert Vernic -Joseph 1837 February 16,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Talbot Memorial Hospital Easton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/24/24 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country)
Illinois 1**□M** 2□ F Months 79 Yrs. Director 215-14-9352 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28e-f ehow other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TNo Federalsburg MD Dorchester Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö United States 21632 7217 Hubbard Road or Iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☑ Yes 2 ☐ No If Yes, Give 143 – 46 Year or Dates: 143 – 46 Specify: White Maryland 21215-0036 1 ☐ Yes 2X ☐XNo Specify: þ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) & P Telephone Co Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Verizon Tel. Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Anna Varner Michael Vernic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7217 Hubbard Rd., Federalsburg, MD 21632 Marian I. Vernic/Spouse f Health Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition pernit. Pages 1 Department of H Importent: If ite any njury or ott E. Sh. Veterans Cemetery 102/20/04 Hurlock, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licenses Mister Federalsburg, MD 21632 P<sub>0</sub> Box 43, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 0515 Physician /Medical Due to (or as consequence of) ry Failure Examiner entilato Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner OPD or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physicien Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ 23e. Did tobacço use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 HNo 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Impatient Certification: To 1 Yes 2 No 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 🐸 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Qay, Year) 29c. License number 30. Name and order's of person who completed cause of death (Item 23a) (Type, Print) Dutchman's Lane Easton, MD 21601 Smoloski Robert M.D 505A 31. Date filed (Month, Day Year) 32 Registrar's Signature

State Registra

Vernic

Robert

State of Maryland / Department of Health and Mental Hygiene 2004 06589 For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Mary Elizabeth VENETTA 08:25A-M 6, 2004 Februard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F Yrs. Director 211-01-6179 86 1917 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itams 23a or 28a-f show other traumatic evant, the Madical Examiner must be notified at 1 ☐ Yes 2 X No Director Washington Maryland Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8507 Mapleville Road 21713 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after I ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify. 3 XWidowed 4 □ Divorced white natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) cafeteria manager education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic eva QDGB. Pages 1 and 2 should be John James Donhiser Teressa Viola Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas H. Venetta - son 11914 Wesley Dr., Hagerstown, Maryland 21742 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/10/04 4 □ Donation 5 □ Other (Specify) Greenlawn Mem. Park Williamsport, Md. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ( as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 menths? Month Day 4□ Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by should be 1 Yes 2 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 NO or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient P 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner-of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Dell To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 29a, Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifie 29c. License number ss of person who completed cause of death (Item 23a) (Type, Print) 22911 32. Registrar's Signature 31. Date filed (Mont State Registrar

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

De Shields,

209

Idleuild Ave.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Feb. 1<sup>Day</sup>, **Physician** Doris Mitchell Walter 2004 0420 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mallard Bay Nursing Home Cambridge Dorchester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F 217-20-5287 76 Yrs Nov.12.1927 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ust be notified at 1 ☐ Yes 2 No Director MD Caroline Preston 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? United States Everly Drive 21707 Items 23a 21655 Completed by Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after dea nent of Health and Mental Hygiene. ant: If item 27 is marked other than "naturel; or Items uny or other fraumatic event, the Medical Event interfer. 11. Marital Status Black, White, etc. I∏Yes 2 No IYes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify: 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Liebold Elsie Mitchell Liebold 2 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21707 Everly Drive, Preston, MD 21655 Jeff Alan Walter/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
E. Sh. Veterans Cem. 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/18/04 Hurlock, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee PO Box 43, Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Securately istornations if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknow Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Inpatient 4 → Ting Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3□ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No n 24 hours after death.

he Funeral Director: A pletely filled in by the fi death. ☐ Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npletely within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title o who completed cause of death (Item 23a) (Type, Print)
FACCLUMD 30 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For Amend Item #23	State of Mar a-b per p	nyland Ny G	829 Cel	rtmen tificat	t of H	ealth a Death	and M			004	06592	2
Ì	Physicia /Medic		Decedent's Name (First, Middle, Last)     MARY ANN WELTY								2. Date of De. Month Februar	Day	2004	3. Time of Death	A
	Examin Funeral	er	4a. Facility Name (If not institution, give st WASHINGTON COUNTY  5. Social Security Number 6. Sex	HOSPITAL 7. Age		st birthday)	101	HAGE	RSTOW	IN	8. Date of Birt (Month, Da	th v Year)	VASHIN 9. Birth	VGTON  place (State or Foreignity)	חן
	Director		213-18-9483  Usuat Residence of Decedent  10a. State 10b. County		85 10c. City,	Yrs. Town or Lo		Jujo			OCT. 1		3   MA	ARYLAND  10d. Inside City Limits	s
	with the Mar	Director	MARYLAND WASHING 10e. Street and Number 243 NORTH MAIN STR				10f. Zip		BOC 21713	NSBO	PRO	10g. Citizen o	of What Cou	•	
036	be filed within 72 hours after death with the Maryland tall Hygiene.  Id other than "natural", or items 23s or 28s-f show other than "natural", or items 23s or 28s-f show event, the Madical Exeminer mast be notified at	by Funeral		2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No tf Yes, Give Year or Dates:		1	Was Deced f Yes, spec	dent of Hi city Cuba			ecify Yes or No Rican, etc.)	- 14. R B	lace - Amer lack, White	ican Indian,	
9500-91212	d within 72 ho giene. or than "natur i the Madical	Completed	15. Decedent's Educ (Specify only highest grade Etementary/Secondary (0-12) 12		-)	16a. Deced (Give lite. I	kind of wo DO NOT u	rk done d	fu <i>ring m</i> osi )	t of workii		16b. Kind of		ndustry OVERNMENT	
Maryland		To Be C	17. Father's Name (First, Middle, Last)  JOSEPH ELLSWORTH BE  19a. Informant's Name/Relationship (Type)			10h Mailir	no Address		NINA	MARI	(First, Middle, E BEND	ER		in Code)	_
	1 and 2 Health tam 27 other tr		MARY ANN RISSER/DAU  20a. Method of Disposition  1 X Burial 2 Cremation 3 Re	GHTER	20b. Pla		BOX	2, W	ATERI	OWN,	WISCO		3094		
Baltimore,	permit. Pages Department of I Important: If it eny injury or o		*4 □ Oonetion 5 □ Other (Specify)  21. Signature of Fineral Service License				. Name ar	nd Addres	s of Facilit L HOM	y 7	2004 7606 010 300nsbo	d Natio	onal I		_
1	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediete Cause (Final disease or condition	ations that caused to cause on each line	the death.	RO /	er the mod	de of dyin	g, such as					Approximate Interval Between 1 2nsh pre Death	
4	/Medical Examiner	ner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	ERE	BRA	TRAC	EREB	RAL B	LEED	E			12 hrs.	
,092	ite be executed hysician and he burial-transit	ical Examiner	Cause (Disease or infury that intleted events c. resulting in death) Last	Due to (or as a		PER ence of): ROSC	IEN LER	15/01 2081	S					YEARS	_
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ords, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions con	enrativ	t not resul	ting in the u	nderlying of	ause give	en in Part I		23e. Did t			the cause of death?	n
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Division of Vit	Phys this al dii	ation: To Be	evaminer?	28a. Date of Injury (Month, Day	y	ER/Outpatier 28b. Time o Injury		28c. Injun Worl	er: 4 □ Nu	rsing Ho	n (Check only o me 5 ☐ Resi 28d. Describe	dence 6 □C		rify)	
Divis	Hospital or Atte 24 hours after des Funeral Directo tely filled in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	. (Specify)						City or To	wn, State)		ral Route Number,	_
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Medical	29a. Certifier  (Check only one)  29b. Signature and title of certifier	er: On the basis of and manner stat	examinati	viedge, deat ion and/or in	vestigation	n, in my o	pinion, dea	th occurr	ed at the time,	date and place	e, and due	to the cause(s)	
γķ	A		30. Name and address of person who co	mpleted cause of de	eath (Item	23a) (Type.	Print) 03//	LAPI	PANS	2 RD	Bool	VSBOR	o Mi	9,2004	_
		ate rar	30. Name and adverses of person who co	04 32. Registra	r's Signat	uto A	och	,				·			

			State Registrer	of Maryland / Depa Ce	artment of Health and rtificate of Death	Mental Hygien	<b>20</b> 04 06593
	Dhuaiai		Decedent's Name (First, Middle, Last)			2. Date of Death Month D	3. Time of Death
	Physicia /Medic	al .			amson, Jr.	February	15, 2004   11:04P M
y	Examin		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Dea		c. County of Death
			Calvert Memorial Ho	-	Prince Freder:		Calvert
	Funeral Director		5. Social Security Number 6. Sex 193–22–4548	74 Yrs.	Months Days Hours Mil		9. Birthplace (State or Foreign Country) Pennsylvania
			Usual Residence of Decedent				
	yland		10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	a-fs	cto	MD Calvert	Lusby			
	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f show the Medical Evarifier must be notified at	Completed by Funeral Director	10e. Street and Number 12645 Calvert Court		10f. Zip Code 20657		citizen of What Country?
	a 23a	eral		ecedent Ever in U.S. 13.			14. Race - American Indian,
	ter de Item	Ę.	Armed	Forces? s 2 \( \text{No} \) 1948-	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	erto Rican, etc.)	Black, White, etc.
980	ursaf aal', or Evam	Ď	If Yes,	Give 1971	1 ☐ Yes 2 No Specify:		Specify: WIIICE
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2	ithin nen Me	nple		/1-40r5+) life.	DO NOT use retired)  r Chief Fire Cont		S. Navy
7	led w lygier har th		17. Father's Name (First, Middle, Last)	- Maste		ame (First, Middle, Maide	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked othar than "natural; or Itema 23a or 28a-f show any injury or othar traumatic event, the Medical Examinating the indifficult and once.	To Be	William Williamson	n, Sr.		na Gross	an ournamy
ary	shoul and Ma s marl umati	۲	19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Number or I		
Ž	and 2 salth a n 27 ls		Gloria Ann Williamson		45 Calvert Court		
Baltimore,	Jas 1 t of He if iter or oth		20a. Method of Disposition 1 □ Burial 2 ◯ Cremation 3 □ Removal from	om State	matory or other place)		Location - City or Town, State
Ē	tmen tant:		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service (forms e		itan Crematory Fe 2. Name and Address of Facility		
Bal	permi Depa Impo any it						Republic, MD 20676
			23a. Part1. Enter the disease, or complications the stock, or heart failure. List only one cause of	at caused the death. Do not en			Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		IAL INFAI	RCTION	Onset and Death
1	/Medical		resulting in death)	to (or as a consequence of):			J. W.
	Examiner	<u>.</u>	Sequentially list conditions, b.	to (or as a consequence of):			
	ed nsit	ulue	cause. Enter Underlying	to (or as a consequence or).			
	be executed sician and burial-transit	Examiner	that initiated events c	to (or as a consequence of):			
760		calE	d				
89		ed	IF FEMALE:				
Вох	th ce tendii or use	an/I	23b. Was decedent pregnant 1 Li		☐Ectopic pregnancy		23d. Date of delivery  Month Day Year
O.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/M	1	egnant at time of death 5 hknown	Other (specify)		
<u>α</u>	that the od by detac		Part II. Other significant conditions contributing I	o death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Records,	sign sign d be	d by	DJD, PARKINSO	NISM		1 🗆 Yes	2 No 3 Probably 4 ☐binknown
5	w requir	lete				24a. Was an	24b. Were autopsy findings available
Re	The law ate has page 2:	Completed				autopsy performed? 1  Yes 2  ✓	
Vital		0	25. Was case referred to medical		26. Place of D	eath (Check only one)	
Ξ	ysic is ca	To B	examiner? 1 Yes 2 No Hospital:	☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)
n of			27. Manner of Death  1 Natural 5 □ Pending	ate of Injury 28b. Time of Injury Injury	of 28c. Injury at Work?	28d. Describe how in	jury occurred
Sio	Attanding or death. actor: After by the fune	catle	2 Accident investigation		M 1 Yes 2 No	Ogé Logation (Street	and Number or Rural Route Number,
Division	l or Attand after death Diractor:	Certification:	determined 286. P	ace of Injury - At home, farm, s uilding, etc. (Specify)	treet, factory, office	City or Town, Sta	
_	Hospita 4 hours Funeral ety filled		(Check only 2 Medical Examiner: On the	e basis of examination and/or i	th occurred at the time, date and pla nvestigation, in my opinion, death oc	ice, and due to the cause curred at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
	To the lewithin 2. To the lecomplet	Medical	one) and r 29b. Signature and title of certifier	nanner stated.	29c. License number	29d. C	Date signed (Month, Dey, Year)
	F 3 F 8		5		D36969	) 2	2/16/04
			30. Name and address of person who completed	cause of death (Item 23a) (Type	1		BY ma 20657
	10+1			District Clarents			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 18 200	2. Registrate Signature  4. Signature	Sperks		

State of Maryland / Department of Health and Mental Hygiene 2004 06594 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Charles Melvin Whittington 7:12 a /Medical February 13 2004 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6173 Owings Beach Road Deale Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Director 219-12-2795 Dec.31,1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Itam 27 is marked other than "naturel", or Itama 23a or 28a-f show other treumstic event, the Medical Examinat must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6173 Owings Beach Road 20751 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ NO If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 Tho Specify: þ 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 carpenter , builder construction permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Itam 27 Is marked oth any injury or other treumetic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Morris Whittington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6173 Owings Beach Rd., Deale, MD 20751 Margaret A. Whittington, wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) St. James Cemetery 02/16/2004 Lothian, MD 21. Signature of Fungral Service Licensee 22. Name and Address of Facility Illiam 20736 Rausch Funeral Home, P.A., Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YEAN COBONAR /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last oue to (or as a consequence or): Examiner law requires that the death certificate be executed and physician a Due to (or as a consequence of): Physician/Medical as attending esn IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ģ in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) Ö the 1 ☐ Yes 2 ☐ No 9 Unknown à ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by as been signal 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? page certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Yes 2 No Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 Accident 5 Pending death. investigation the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signatur , and title of certifier 29c. License number 005158 02/13/2004 6131 SHADY SIDE RU HADY SIDE, 11d 20764 1105158 30. Name and ad vess of erson who completed cause of death (Item 23a) (Type, Print) STEINFELD 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar Coorte

		•	For State Registrar	State o	f Marylan	d / Depa <i>Cei</i>	artment <i>tificate</i>	of He	ealth a Death	ind M	lental Hy	/giene Reg. No		4	06595
	Physicia		1. Decedent's Name (First, Middle, Las HAZEL MAE WRIGHT	t)							2. Date of D Month FEBRUA	Da	2002	ar <del>I</del>	3. Time of Death 9:30AM M
	/Medic Examin		4a. Facility Name (If not institution, give		mber)		4b. City, To SHARP			f Death		1	:. County of C		
	Funeral Director		Social Security Number 6. S		7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months		If Under 2 Hours	Min.	8. Date of B (Month, D MAY 2	irth ay, Year 191	9. 4 D	Birthpla Count ELA	ace (State or Foreign NARE
١	show	o.	Usual Residence of Decedent	`	1	, Town or Lo								10	d. Inside City Limits
Les	with the has or 28e-f	Funeral Director	10e. Street and Number  301 FOURTH STREET		. 51	IAIL TO	10f. Zip C	ode 861				10g. Ci	itizen of Wha	t Count	ry?
36 K	filed within 72 hours after death with the Maryland Hygiene. sther then "neturel", or Items 23a or 28e-f show ent, the Medical Examinar must be multified at	by Funera	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced		2 (XNo			nt of His y Cubar	spanic Origin, Mexican	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - / Black, V Specify:	Vhite, e	
1215-00	within 72 hou ane. then "neture he Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation		(Give life.	dent's Usual kind of work DO NOT use STRESS	done d retired)	tion uring most	of worki	ing		Cind of Busin		ustry UFACTURING
/land 2	uld be filed Mental Hygi arked other	To Be Co	17. Father's Name (First, Middle, Last) CHARLES HAZEL HI	TCHENS					MART	ГНА ]	) (First, Middl DICKER	SON		Sumame)	
re, Man	ss 1 and 2 sho of Health and item 27 Is my r other treum		19a. Informant's Name/Relationship (1) MARTHA JEAN BRADL 20a. Method of Disposition	EY/DAUG	20b. P	P. O.	BOX 2	292 <b>,</b>	SHAI	RPTO	NN, MA Date	RYLAI		61	
22. Name and Address of Facility of Funeral Service (sich service) ZELLER FUNERAL											2004 P. O	. воз	X 207		ARYLAND
•	Physician /Medical Examiner	Examiner	2 See Parm. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury)  106 MAIN STREET, EAST NEW MARKET, MD 2  Do not enter the mode of dying, such as cardiac or respiratory arrest,  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											Approximate Interval Batween Onset and Death M IN S  MTM 5	
. Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	dical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	□Ectopic pre						delive	ry Day Year				
ls, P.O.	w requires that the death cer s been signed by the attendin should be detached for use	by Physician/Me	1   Yes 2   No 9   Unknown	nderlying cau	use give	n in Part I.	,		tobacco	_	te to the	e cause of death?			
Record	The Isw reruires that the death certification is been signed by the attending page should be detached for use as	Completed			r						24a. Wa aut per 1 ☐ Yes	opsy formed?	prior deat	to com	osy findings available apletion of cause of 2 \( \text{No} \)
Division of Vital Records, P.O	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To Be C	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  2 Accident Gould not be determined	28a. Date ( <i>Mor</i>	Inpatient 2  of Injury onth, Day Year) e of Injury - At ha	ER/Outpatier 28b. Time of Injury	f 28	c. Injury Work	er: 4 □ Nu	rsing Ho		sidence how inju	ury occurred		)  Route Number,
Ϊ́Ο	t hours unerel	edical Cert	29a. Certifier 1 Certifying Pr (Check only one) 1 Medical Exar	ysician: To th	e best of my kno	wledge, deat	h occurred at vestigation, i	t the tim	ne, date an pinion, dea	d place, th occur	and due to th	e cause(	s) and manne	er as sta	ated. the cause(s)
	To the h within 24 To the F complete	Med	29b. Signature and title of certifier	h lw	m MO		29c.	License	number 168	8	~	29d. D	ate signed (A	onth, L	Day, Year)
•	Ste	ate	30. Name and address of person who	Completed cau	use of death (Item MI) Registrar's Signa	400 (	Print)	w	Shre	A	we,	Jali	puy,	Mel	21804

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 06596 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 16, 2004 12:20 P.M Virginia Woodson Bessie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Anne Arundel Hospice of the Chesapeake Hospice House Linthicum If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 M 2 F 240-32-6784 75 January 9, 1929 North Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f ahow the Medical Examiner rount be notified at 1 ☐ Yes 2 ☐ No Baltimore City Maryland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 5853 Arizona Ave. 21206 items 23a Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 ₩ Widowed 4 Divorced "natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Technician Nursing 12 marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill timent of Health and Mental Heart: If Item 27 is marked ott jury or other traumatic even Be Willie Barco Chanie Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Taylor (Daughter) 11103 Tadmore Place Largo, Maryland 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) New Burying Grounds February 21,2004 South Mills, NC. 21. Signal to of Eun (ra) hervice Licensee 22. Name and Address of Facility Adams Funeral & Memorial Care 814 Bestgate Road Annapolis, Maryland 21401 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician una cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physiclan/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 4 Pregnant at time of death signed by the a P.0. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha 20 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospice Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2 2 No 1 Yes 2 this 28a. Date of Injury (Month, Day Year) After the 27. Man of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide within 24 hours after To the Funerel Direct 4 | Homicide 1 portifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0060050 2-18-2004 mulch Cerosa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nahrukh m. HUSSain Kaiser Permanere 31. Date filed (Month, Day, Year) FEB 1.8 2004 3 Registrar's Signature State Registrar

06597 State of Maryland / Department of Health and Mental Hygien [ ] [ ] [ 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Year Physician KATHLEEN ARNIEL FEBRUARY 26. 2004 9:50 A. LEE /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE 8111 BARKSDALE ROAD Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours Min 1 ☐ M 2 ☐ F Yrs. 220-48-0353 7/9/1951 MARYLAND Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or Itema 23s or 28s-1 show other traumatic event, Ite Mudical Exuminat must be notified at 1 ☐ Yes 2 🕅 No TOWSON BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8111 BARKSDALE ROAD 21286 USA death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Item any injury or other traumate. 1 Yes 2 No If Yes, Give Year or Dates: 1

Never Married 2

Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. þ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) COMPUTER ANALYST **INSURANCE** 4 YEARS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DORIS D. DAVIS 2 EDWARD F. ARNIEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8622 CHELSEA BRIDGE WAY BALTIMORE, MD SUSAN D. DUNHAM SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State DULANEY VALLEY MEM.GAR. 3/1/04 TIMONIUM, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a **Examiner** Sequentially list conditions. Sequentially list conditions, r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-transit Due to (or as a co P.O. Box 68760, ed by the attending physicien detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2/X No.
9 Unknown Year Month Day 4

Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the should be detach 23a. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No certificate has page 2 1 Tyes ospital or Attending Physician: Thours after death.

uneral Director: After this certificate filled in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 2 TER/Outpatient To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital within 24 hours a To the Funeral C 16 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
22 Medidal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ar title of rtifier 30. Name and address of per ath (Item 23a) (Type, Print) O OWSO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 03 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2001. 06598 For State Registrar Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** David Elmer Akehurst, Jr. 02 27 2004 8:00 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Center If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 X M 2 □ F 69 Yrs. 10/04/1934 Maryland Director 218-32-5404 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or Itams 23a or 28a-f shov event, the Medical Exemptor must be notified at 1 ☐ Yes 2 No Director Baltimore Kingsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11509 Cedar Lane 21087 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates:1955–1957 within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed within thealth and Mental Hygiene. Item 27 Is marked other than Engineering Draftsman Baltimore County 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edythe Long Elmer Akehurst, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11509 Cedar Lane - Kingsville, MD Lois Akehurst (wife) 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 Burial 2 Cremation 3 Removal from State Camp Chapel Church Cem 03/03/2004 Perry Hall, Maryland \*4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee CA 11750 Belair Road - Kingsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MONTHS MULTIFORME Physician OLIOBASSOMA /Medical Due to (or as a consequence of): **Examiner** S. pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records, 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha performed? 2∏ No 1 Yes 2 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Division 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide within 24 hours a
To the Funeral C
completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 50303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) horses it Baltimore mD 6601 N. mp narles 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 0 3 2004

DHMH 17 Rev 1/2001

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06599 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician EDWARD** ALLEN JR. FEBRUARY 11:05 A 28 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ANNE ARUNDEL Co. 417 CARVEL BEACH ROAD SALTIMONE 1 Year | If Under 24 Hrs. If Under Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 85 217-01-6180 Yrs. Feb. 21 1919 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or than "naturel", or Itema 23a or 28a-f show the Wedical Examinar must be notified at 1 ☐ Yes 2 No Anne Arundel Co. Md. Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21226 417 Carvel Beach Road death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 TYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: δ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Atlantic and Gulf 0 Longshoreman 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Allen Sr. Mary Edward Schaaf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s of Health ar item 27 ls 417 Carvel Beach Road, Baltimore, Md. 21226 (Wife) Ilma S. Allen 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of t 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Glen Burnie, Md. Glen Haven Memorial Pk.03/02/04 21. Signatu 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. of Funeral Service Licensee m00922 3204 Mountain Road, Pasadena, Nd. 21122 a sease. Complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator arrest, mure. List only one cause on each line Approximate Interval Between Onset and Death 23a. Part Enter the Immediate Cause (Final ears **Physician** disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a donsequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? sate has been signed by the atte-page 2 should be detached for Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 21 No 1 TYes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check Hospital: 1 Inpatient Other: No No Medical Certification: To 1 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home esidence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Magner of [2 28b. Time of 28d. Describe how injury occurred Natura 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 No investigation 2 🗌 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A 0 2106 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 06600 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** С. 25,2004 Robert Bachman February /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral X**X M 2□ F Months Days Hours Yrs. 414-14-1007 85 Nov. 22,1918 TN Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other then "naturel", or Items 23e or 28e-1 show other treumatic event, the Madical Examinar must be notified at MD Stevensville 1 ☐ Yes 2 ☐ No Queen Anne Directo 10f. Zip Code 21666 filed within 72 hours after death with the 10e. Street and Number 514 Victoria Drive 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No. If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specity: Specify: White Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Utilities permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Importent: If Item 27 is marked other the eny injury or other treumatic event. The Machinist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bachman Ernest Α. Marie Marx 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael Bachman 1701 Dunwoody Blvd Knoxville, TN 37919 Nephew 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Louden Park Cemetery 3-1-04 1 ABurial 2 Cremation 3 Removal from State Baltimore, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave Annapolis, $\mathtt{MD}$   $_1$ 21401 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) -nysician /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 Yes 2 🗆 No 2 1 No 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 /npatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of After 1 \_\_\_\_atural 5 Pending 1 ☐ Yes 2 ☐ No investigation matrin 24 hours after death. Fo the Funerel Director: A 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of 1 completed cause of death (Item 23a) (Type, Print) 31. Date filed MAR DO. 22 Registrar's Signature 3ª2004 State Registrar

			1 - For Amend Item :	<b>State</b>	e of Marylar er Inform	nd / Depa mant Cei	artment	of H	ealth a	and M 4, ga	ental Hy	giene2	2004	06601	
	Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year								3. Time of Death 4 8:20a M				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death				4c. County of Death			
Н			Heritage Genes	is El	dercare	2		ndal			Baltimore				
I	Funeral			Sex 1 □ M 2 🕱	M OCTE			If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.			8. Date of Birth 8/23/28 9. Birthplace (State or Foreign (Month, Day, Year)				
	Director		218-26-4230 19-36-4130 Usual Residence of Decedent	10 W 20	. 7	5 Yrs.				+	Aug. 23	3,200	4 Mar	yland	
	and **	Director	10a. State 10b. County		ocation							10d. Inside City Limits			
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	286-		10e. Street and Number		10f. Zip Code						10a. Citize	n of What Cou	ntrv?		
	with 3a or		7232 German Hi	ll Ro	Road			21222					U.S.A	•	
	72 hours after death with the Maryland "natural", or frame 23a or 28e-1 show dical Examinar must be notified at	Funerai	11. Marital Status	12. Was I	12. Was Decedent Ever in U.S. Armed Forces?			Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica			cify Yes or No	fy Yes or No- 14. Race - American Indian,			
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8	ral', c	1 by	3X Widowed 4 ☐ Divorced		, Give or Dates:		1 ☐ Yes 2	( XVO	Specify:			S	pecify: Bl	ack	
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	d 2 s th an 17 ls r treur		Yolanda Dorsey				-								
	s 1 an f Heali item 2 other		20a. Method of Disposition	/ - G	20b.	Place of Dispo	sition (Nam	e of			ate		tion - City or To		
jo	0°= 5		1 □Burial 2 □ Cremation 3		rom State	cemetery, crei	natory or ot	her place		15/	2004				
Baltimore,			* 4 ☐ Donation 5 ☐ Other (Special Signature of Further as a rivide Lice	_/	Ga		2. Name and							lls,M.D.	
Ba	permit. Departuimportui		1 Dete	. J	/					wu				me Inc.	
-			2501 Gwynnsfalls Pkwy Balto M D 21216  23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate												
			shock, or heart failure. List only one cause on each line.  Immediate Cause (Final												
	/Medical		disease or condition resulting in death)												
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			resulting in death) Last	Due	Due to (or as a consequence of): CHRONIC RENALFA					ALLUPE UNE			100000		
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Box	eath certific attending p I for use as I	an/l	23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy					23d. Date of del Month					
	at the dea by the at tached fo	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4 Pregnant at time of death 5 Other (specify) 9 Unknown  contributing to death but not resulting in the underlying cause given in Part I.			·				Month Day Year			
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Division o	tending leath. tor: After the funer	lon:	27. Mann of Death 1 atural 5 ☐ Pending		28a. Date of Injury (Month, Day Year) 28b. Time of Injury			Work?			28d. Describe how injury occurred				
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	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by		(Check only 2 Medical Expone)	aminer: On t	iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)								Day, Year)			
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	Sta Regist		31. Date (MAK 0 3 2004	Siene	32. Registrar's Sign	nature					/	,			

within 72 hours after

Baltimore, Maryland 21215-0036

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State of Maryland / Department of Health and Mental Hygiene 2004 06602 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 28,2004 12:02 a M **Physician** Earl William Bundy, Jr. /Medical 4b. City, Town, or Location of Death BALTIMORE CITY 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** UNIVERSITY HOSPITAL N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Sept. 14, 1986 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** 1**X**M 2□ F 17 214-13-3369 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r then "natural", or Itams 23e or 28e-f show the Medical Exertines Lust be notified at Yes 2 □ No N/A MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1810 Thomas Avenue 21216 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 Marned 1 ☐ Yes 2 TNo Specify: Specify: Black δ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A markad other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ould be I , 2 should be alth and Mer Earl William Bundy, Sr. Pearl Turner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a Pearl Turner - Mother 1810 Thomas Ave. Balto., MD 21216 20b. Place of Disposition (Name of commeter, crematory or other park Memorial Park item 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ites 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) 3/6/04 Balto. Co., MD 21. Signature of Funeral Servi a Licensee 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto., MD 21216 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causefor each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) gunslot Multiple Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
Yes 2□ No autopsy performed? Yes 2□No 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ← FP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 √ Yes 2 □ No 2 After this 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending Susject Shot 1 Natural 1 ☐ Yes 2 💆 No 2/27/04 М investigation death. 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide the car on the street 1800 Thomas Ave. Battimore Lity, Mi) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME February 28,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZABINUAL 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) 2004

32 Registrar's Signature 1 Carone

or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.0

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 2 11 11 06603 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:10 A M FEBRUARY 29 2004 EDDIE R. BURNSIDE /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALL EGANY CUMBERLAND MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer)
Jan. 12, 1932 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1⊠M 2□F **Director** 235-52-5372 72 West Virginia Usuel Residence of Decedent death with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f show item 27 is marked other than "natural", or items 23s or 28s-1 show other trsumatic event, the Medical Example at must be notified at 1 Tyres 2 □ No Director WV Mineral Keyser 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 55 South Main Street 26726 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Item any injury or other traumatic svent, the Medical Element Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Korean Year or Dates: Conflict 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Propellor Mechanic Aircraft Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gail Burnside Lena Kelly 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally A. Burnside/ Wife 55 S. Main Street Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State March 1 ^ 4 □ Donation 5 □ Other (Specify) The Cumberland Crematory Cumberland, Maryland 2004 21. Signature of Funeral Servine 22. Name and Address of Facility Smith Funeral Home Brian 0 85 S. Main Street Keyser, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cell **Physician** mully /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year for Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy page 2 No 1 Yes or Attending Physicisn: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 3□ DOA Certification: To 1 Yes 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide after within 24 hours a To the Funeraf I 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmad 425 Kent Ave. Cumberland, Maryland Afaa M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Acertis MAR 0 3 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06604 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician MARCH 1, <sup>□</sup>2004 BERG 7:45 A GUSSIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner #301 BALTIMORE 5833 PARK HEIGHTS AVENUE N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) MAY 4,1922 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F CZECHOSLOVAKIA 097-14-8516 81 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits World 123a or 28a-f ahor 1 ☐ Yes 2 ☐ No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5833 PARK HEIGHTS AVENUE #301 21215 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, other then "neturel", or Item Black. White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: þ WHITE 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12 College (1-4or 5+) SALES RETAIL wormit. Pages 1 and 2 should be files.
Department of health and Mental Homogrant: if item 27 is more any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JACOB **GUBNER** FANNIE ITZKOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3710 KINGWOOD SQUARE - BALTIMORE, MD 21215 DEANNA COTTON / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State \* 4 □ Donation 5 □ Other (Specify) BETH DAVID CEMETERY 3/2/2004 CONKLIN, NEW YORK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. ZHUrand C. KMM REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC OBSTRUCTIVE /Medical Due to (or as a consequence of): Examiner POVENTILATOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 1XX Yes 4 Dunknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 R/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the within 24 hours after death To the Funeral Diractor: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of



29c. License number

JUITE 14

42827

29d. Date signed (Month, Day, Year)

MARCH 1

ONINGI MILLS.

State of Maryland / Department of Health and Mental Hygien 2014 06605 Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician BFCK** bruary 24 2004 RUTH /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE LEVINDALE HEBREW HOME If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | B. Date of Birth Day Year)
DEC. 4,1916 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 87 Yrs MASS 048-05-7504 Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 Ves 2 □ No BALTIMORE Director N/A 10f. Zip Code 10g. Citizen of Whal Country? 10e. Street and Number 21209 U.S.A. 6206 BENHURST ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PIANIST ENTERTAINMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fi of Health and Mental H I item 27 is marked off Be GOTTLIEB KRUGMAN IDA ABRAHAM ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6206 BENHURST ROAD - BALTIMORE, MD 21209 LOUIS BECK / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
important: If iten
any injury or oth 1 ABurial 2 Cremation 3 Removal from State ARLINGTON NATIONAL CEM. 3/2/2004 FT. MYERS, VA \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service bio SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ementia 4 ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and ned for use as the burial-transit Due to (or as a consequence of): Box 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, oulcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş pe 1 ☐ Yes 2 XNo 3 Probably 4 □Unknown page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, elc. (Specify) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier no completed cause of death (Item 23a) (Type, Print) 30. Name and address of persen 10, ne 2434 W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

		1 - For State Registrar	State of Mary	land / Depa <i>Cei</i>	artment of H	lealth and M Death		giene 2 ( Reg. No.	004	06606	
		1. Decedent's Name (First, Middle, Last	2. Date Mont			ath Day	Year	3. Time of Death			
Physic /Medi		SUSPAL, BAH	LER				Februa	29	2004	0837 AM	
Exami		4a. Facility Name (If not institution, give				r Location of Death		4c. Count	ty of Death	N/A	
		5. Social Security Number 6. Se		yrs. last birthday)	Baco Mo		8. Date of Birt	th	9. Birthp	lace (State or Foreign	
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with the or :	Dir	6350 RED CEDAR PI	ACF #310			21209		U.S.A.		•	
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tiled within 72 hours after death with the Maryland Hygiene. Hygiene. Inter then "natural", or Items 23a or 28a-1 show ent, the Medical Examinat must be multily at	d by	3 X Widowed 4 □ Divorced	Year or Dates:					16b. Kind of			
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Te, IV		THOMAS A. BAKER		20b. Place of Dispo	osition (Name of		Date	20c. Location		wn, State	
Pages nent of I		1 X Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	•	matory`or other plac	CEM. 3/1/	2004	PFI	STERSI	OWN, MD	
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DIVISION Lor Attending after death. Director: Afte	iffica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
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DIVISION Of VITA  To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the tuneral director,	Med	one) and manner stated.  29c. License number 29d. Date signed (Month							ned (Month,	Day, Year)	
8 4 5		Afthan	D53		MARCI	MARCH 1 2004					
18		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
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State of Maryland / Department of Health and Mental Hygiene 2004 06607 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Kennern Februari 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Bayview/1/edica/(Enter ohns Hopkins If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year 5. Social Security Number 6. Se 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ★M 2 ☐ F Director Virginia 229-24-2974 Oct. 8,1926 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show item 27 is marked other than "natural", or Items 23s or 28s-f shov other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 51 Avalon Avenue 21222 United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify 3 ₩ Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Years Tractor Operator Steel Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 4 be t 2 Arthur H. Brads Mary Louise Lewis Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Bradds / Son 2235 Lincoln Ave. Edgemere, Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State ō <u>=</u> 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department Importent: If any injury or 4 ☐Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 3/3/2004 Middle River, Maryland permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Findisease or condition End Stage **Physician** LIVER MISECUSE /Medical resulting in death) Due to (or as a consequence of): Examiner Inclear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ng physician and as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death jo in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ned by the a 1 Yes 2 No 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 🕱 No 3 Probably 4 Unknown should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page, certificate 2 X No 1 ☐ Yes Physicien: funeral director, 25. Was case reterred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and little of certified 23009 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Baltimore, MD 21224 TANESHA 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 2004 06608 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** RVING 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE SECOURS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Year) 06/20/1915 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1⊠M 2□F Virginia 88 Director 215-18-9689 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r then "natural", or itema 23a or 28a-f ehow the Medical Examiner must be notified at 1ÆYes 2□No Baltimore Funeral Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21216 1700 Edmondson Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1944 1 ⊠Yes, 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Navy Curtis Bay I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Coal Pier Worker UNKNOWN d 2 should be filed w h and Mental Hygier 7 Ie marked other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Ie marked of any injury or other traumatic ever 9068. Virginia Johnson Louis Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hope A. Porter / Caretaker N. Fulton Ave., Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Special) Garrison Forest Ceme. 03/05/2004 Owings Mills, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service License 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HCUTE Physician /Medical Due to (or as a consequence of) **Examiner** RHABE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed SEPSI use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year jo in the past 12 months? 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown þ should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 3 Probably 4 □Unknown 2 No 1 Tes pieted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 page 2 Com 1 ☐ Yes 2 ☐ No certificate 2X No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Unpatient 2 ER/Outpatient 3 DOA ۵ 1 ☐ Yes 2 No ð this After thi tuneral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending Division 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 03-1-2004 ganlers 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RANDALLSTOWN DWARD DR.OBAZER 5309 A OLD COURT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 06609 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer **Physician** :390 Louise Ann Custis FEB 23 2004 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE SAINT AGNES HEALTHCARE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2-26-1923 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF 227-24-0456 80 Director Vа Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County worle rat', or items 23a or 28a-f ebov Examiner must be notified at 1 Yes 2 No Director Md Balto Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 USA 8826 Harkate Way Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced "natural" if Health and Mental Hygiene. Hem 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) A Elementary/Secondary (0-12) Homemaker Home 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Ayers Bessie Doughty ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvette Custis - Daughter 8826 Harkate Way Randallstown, Md 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of P important: If its eny injury or ot once. t Bunal 2 Cremation 3 Removal from State Druid Ridge Cemetery 2-28-2004 Balto, Md \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H West permit. 21. Signature of Furieral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Wabash Avenue Balto, Md 21215 Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition PNEUMONIA **Physician** DAYS resulting in death) /Medical Due to (or as a consequence of): Examiner DAYS VASCULAR ACUTE CEREGRAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate has 2 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death. To the Funsral Director: Alter Injury 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide filled Medical 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P15633 KHANDAGLE PHYSICIAN 1004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE BALTIMOITE MARYLAND 2122 KHANDAGLE <u>A</u>URA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 3 2004

		1 - For State Registrar	State of Ma	aryland	l / Depa <i>Cer</i>	rtmer tificat	t of H	lealth Death		H	g. No.	2001	+ 066
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/Medica	al -	Mary R.  4a. Facility Name (If not institution, give	Coale			4h City	Tour	Location	of Death	Februar		County of Death	11:33 a
Examine	r	Stella Maris	street and number)			Timo		Location	OI Death			ltimore	
Funeral		Social Security Number 6. S		e (In yrs. la	st birthday)	If Under	1 Year	If Unde	r 24 Hrs.	8. Date of Birth (Month, Day,			place (State or Forei
Director	-	Usual Residence of Decedent	□M 2 <b>⁄</b> 2F	86	Yrs.	Months	Days	nours	Min.	June 22	, 1	917 Mar	ryland
anytar show	٦	10a. State 10b. County	_		Town or Lo	cation						1	10d. Inside City Limi 1 ☐ Yes 2 ☑ N
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with with		2300 Dulaney Val	lev Rd			101. 21	2109	93			Jg. Cill	USA	iii y :
death ms 2	nera	11. Marital Status	12. Was Decedent E	Ever in U.S	. 13. V	Vas Dece			rigin? (Spec	cify Yes or No- Rican, etc.)		14. Race - Americ	
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23e or 28e-1 show eney injury or other traumatic event, tra Medical Examinar must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	ło		Yes, spe				tican, etc.)		Black, White,  Specify: White	
Baltimore, Maryland 21215-0036  Dermit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural; or my injury or other traumatic event, tra Medical Examples.  To De Commission of the traumatic event.	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5-	+)	16a. Deced (Give life. L	lent's Usu kind of wo DO NOT u	al Occupa rk done d se retired	ation during mo	st of workin	9	16b. Ki	nd of Business/In	dustry
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be file doth doth	Be	17. Father's Name (First, Middle, Last)								(First, Middle, M	laiden	Sumame)	
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Mar 12 sh h and 7 is m traum	1	19a, Informant's Name/Relationship (7								Route Number,	_	r Town, State, Zip DDC	Code)
Health		Mrs. Karen Lally/ 20a. Method of Disposition	vaugnter	20b. Pla	/ UD ice of Dispo:			Dr.	-			cation - City or To	own State
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	/Medic		TRANKIN	HENry	CAGE	K	th City Town	ar Lagation of E			ounty of Death	10:30AM
	Examin	er	4a. Facility Name (If not institution	- /	1		4b. City, Town,		Death		ware	
1	<u> </u>		7220 Mon 5. Social Security Number		Age (In yrs. last	t birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	rth		lace (State or Foreign
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g.			23°. art1. Enter the disease, sho , or heart failure. Lis	or complications that caus st only one cause on each	sed the death.	Do not en	ter the mode of dy	ing, such as ca	ardiac or respiratory a	arrest,		Approximate Interval Between Onset and Death
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-	K		30. Name and address of person	on who completed cause of	of death (Item 2	3a) (Type		9				
_	1_\		J. Belle Bau	man, 5841	WaSHir	ato	n Blvd	Elkrid	lge MD 21	075		
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State of Maryland / Department of Health and Mental Hygiene 2004 06612 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23 Day Month Year **Physician** 1 8150AM hound Feb. 2004 /Medical Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner H Howard County Celumbia enera oward If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min. Months Days 1**X** M 2□ F Yrs. Ohio **Director** 279-03-5010 89 0/15/1914 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County "natural", or items 23a or 28a-f ahow edical Examiner must be notified at 1 Yes No Directo MD Howard Columbia 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 7110 Minstrel 12. Was Decedent Ever in U.S. Armed Forces? 21045

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after death Funeral 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 2 No WW 2
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 white by X□XWidowed 4 □ Divorced the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Manufacturing 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Heelth and Mental Important: If item 27 is marked o Albert Thomas Connar Sarah Elizabeth Wade 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5884 Moss Creek Drive, Tom Connar (Rev.) son Mt. MD. Airy, 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Balto/Wash Crematory (25/2004 1 ☐ Burial 2 XCremation 3 ☐ Removal from State LAurel, Md. injury or \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. 5555 Twin Knolls Rd., Columbia, Md. 21045 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Statis **Physician** /Medical Due to (or as a consequence of): **Examiner** 11400 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2. No Hospitel or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural м 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number Feb 23 20045 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 715 10501 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 06613 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>25</sup>, 2004 **Physician** Charles Elmer Creswell February 10:00 P.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Eldercare-Loch Raven Loch Raven Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 10/25/1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 85 yrs. 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 1 F 216-03-0317 ATabama Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Exprinter must be published. and once. MD Harford Glen Arm 1 Yes 2XXNo Completed by Funeral Director 10e. Street and Number 4204 Echo Valley Road 10f. Zip Code 21057 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Marned If Yes, Give Year or Dates: WII 1 ☐ Yes 2 No Specify. Specify: White 3€Widowed 4 □Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles E. Creswell, Sr. Charlotte Colton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles W. Creswell - Son 4204 Echo Valley Rd. Glen Arm, Md. 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Metro Crematory 02/27/2004 Catonsville, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Sigrature of Funeral Service License 22. Name and Address of Facility Cvach/Rosedale Funeral 1211 Chesaco Avenue Rosedale Maryland 2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** grad stass resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 funeral director, page 2 should be 3 Probably 4. Unknown 1 ☐ Yes 2 ☐ No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performe 2/2 No 1 Yes 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 47 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 3□ DOA 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

wan our

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06614 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MONTH Day Year **Physician** 2-00 AM CHARLES DANZA 03 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) OCT. 5, 1909 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1X M 2□ F 94 Yrs MARYLAND 216-01-4053 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. It and Mental Hygiene 27 is marked other than "natural", or Items 23a or 28a-1 shoy treumatic event, It a Madical Examiner must be natifiled at MARYLAND ANNE ARUNDEL SEVERN 1 ☐ Yes 2 X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8034 QUARTERFIELD RD. 21144 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST SHIP BUILDING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SALVATORE DANZA CONCETTA LEONE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) outment of Health a cortent: If Item 27 Is injury or other tree CHARLOTTE H. SLONE / DAUGHTER 4100 YARDLEY CT., BOWIE, MARYLAND 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State GLEN HAVEN MEM. PK. \* 4 □ Donation 5 □ Other (Specify) GLEN BURNIE, MARYLAND 21. Signature of Foreral Service Licensee permit.
Departr
Importe
any injt KIRKLEY-KUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA **Physician** 4 DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). physician and s the burial-transit Due to (or as a consequence of): Physician/Medical ned by the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CONGESTIVE HEART FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown FIBRILLA ATRIAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t rector, page 2 s 2 1 Nó 1 ☐ Yes 2 ☐ No 1 Yes is after deau...
rel Director: After this cerus...
is by the funeral director, pr 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitel or within 24 hours a

To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 0 6 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MARCH

State Registrar 31. Date filed (Month, Day, Year)

NORTH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 0 3 2004

M. SHIRAZI, M.D.



ARUNDEL

HOSPITAL. MD

21061,

Baltimore, Maryland 21215-0036

Box 68760

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Records,

of Vital

Division

		1	For State Registrar	State of Maryland / De	epartment of Health and Certificate of Death	Mental Hygie	
			Decedent's Name (First, Middle, Last		1	2. Date of Death	3. Time of Death
	Physicia /Medic		Turner baby	girl OEST	any	grants .	21 2004 0035 M
Au.	Examin	_	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea	ath	4c. County of Death
			Mercy Hospit  5. Social Security Number 6. Se		100		9. Birthplace (State or Foreign
	Funeral Director			JM 2  ▼F  Yrs	Months Days Hours Mi	n. (Month, Day, Ye	2004 USA
	ש		Usual Residence of Decedent	10c. City, Town o	r Location		10d. Inside City Limits
	arylar ehow	-	10a. State 10b. County	0.44.1			1 AYes 2 □ No
	the M	Director	10e. Street and Number	DHITI	MORE	10g.	Citizen of What Country?
	3e or	<u>ā</u>	4784 Eliso	n ALE	2/2/	26	USA
	deeth	Funeral	11. Marital Status		13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put	(Specify Yes or No-	14. Race - American Indian, Black, White, etc.
98	within 72 hours effer deeth with the Maryland ene. then "natural, or Neme 28a or 28a-f ehow na Madical Examinar nural ba molillied at		1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 No Specify:		Specify: BIACK
215-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edi	Year or Dates:	ecedent's Usual Occupation	168	b. Kind of Business/Industry
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Maryland	should nd Men marke	ပ	19a. Informant's Name/Relationship (T	(NEX	hailing Address (Street and Number or	Bural Boute Number C	ity or Town State Zin Code)
Z	d 2 sl th en t7 ie r treur		Shirelle Tul	RAIFR 47	84 Elison AVE	BALLEMA	2 21206
ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition	cemetery	isposition (Name of crematory or other place)	Date 200	c. Location - City or Town, State
Ë	Pages nent of nnt; if it		1 ØBurial 2 ☐ Cremation 3 ☐ 1 ☐ Other (Specify,	Removal from State		01/2004	Baltimore, MD
Baltimore,	permit. Pages 1 and 2 should be flied within 72 hours efter deeth with the Marylan Department of Health end Mentel Hygiene. Importent: If item 27 is marked other than "natural; or iteme 23a or 28a-1 show any injury or other treumatic event, the Modical Examinar must be notified at ORCE.		21. Signature of Funeral Service Licens		22. Name and Address of Facility Sterling Ashton So		
			23a. Part1. Enter the disease, of comp	lications that caused the death. Do not	736 Edmondson Ave tenter the mode of dying, such as card	ac or respiratory arrest	Approximate Interval Between
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9		Med	IF FEMALE:				T
Вох	es thet the death certifi igned by the ettending be deteched for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
	he de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant at time of death 9∏Unknown	5 Other (specify)		
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of Vital Records,	quires n sign uid be	q pe	NIA.			1 ☐ Yes	2 No 3 Probably 4 ☐ Unknown
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H.	0 - 0	E				performed	d?   death?
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Division	or Atteriter dea	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	ot and Number or Rural Route Number, State)
Ω	pital o	Ce	29a. Certifier 1 ☑ Certifying Ph	/sician: To the best of my knowledge,	death occurred at the time, date and pla	ce, and due to the caus	se(s) and manner as stated.
	To the Hospital or Attendi within 24 hours effer death. To the Funeral Director; A completely filled in by the fu	edical	(Check only 2 Medical Examone)	iner: On the basis of examination and/ and manner stated.	or investigation, in my opinion, death oc	curred at the time, date	and place, and due to the cause(s)
	To To To To	Ž	29b. Signature and title of certifier		29c. License number		hate signed (Month, Day, Year)
				MIEH LANGROUDI)			
			MEHRAN HAMZE	I I ANT POUR -IL	wardty of Manile	and 22 Su	the Greene Street.
	St Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	sports		

			For State Registrar	State of Mar	yland /	Department Certifica	nt of H	ealth and N	lental Hy	giene 2 (	004	06616
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last James Lewis Embre 4a. Facility Name (If not institution, give	ey	tocm	tal 4b. City	Town, or	Location of Death	2. Date of De Month	Day /	Year OOT by of Death .more	3. Time of Death 5:20 PM
_	Funeral Director		5. Social Security Number 6. Se 317–46–9702		in yrs. last	birthday) If Under Months	r 1 Year Days		8. Date of Birt (Month Da Aug • 13	1947	9. Birthp Kent	olace (State or Foreign CCky
Embrey	death with the Maryland mms 23a or 28a-f show r must be matified at	ctor	Usual Residence of Decedent  10a. State 10b. County Vest Virginia Morgan	1		own or Location Cacapon					1	0d. Inside City Limits 1 ☐ Yes 2 [X]No
En	h with th	al Dire	10e. Street and Number 70B Moss Lane				p Code 422			10g. Citizen of United		•
7	irs after deat	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1 Year or Dates:		13. Was Dece If Yes, spi 1 \( \subseteq Yes		spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes <i>o</i> r No Rican, etc.)	- 14. Ra Bl	ice - Americack, White,	
ames L	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mendal Hygiene.  If Health and Mendal Hygiene a statural, or Items 23a or 28a-f show other traumatic event. Ite Medical Expresser intent be notified at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation	16	6a. Decedent's Usi (Give kind of w life. DO NOT			ing	16b. Kind of		
Maryland 2	should be filed nd Mental Hygi marked other umatic event,	To Be Co	17. Father's Name (First, Middle, Last)  James Lewis Embr	еу				18. Mother's Nam Helen Dy	re			
	nd 2 sho alth and 27 is m or traum		19a. Informant's Name/Relationship (T Barbara Beat- Sis		1	9b. Mailing Addres	s (Street a	ough Cour	rt, Loui	sville	, Kent	tucky 201
Baltimore	permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any Injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,			of Disposition (Na etery, crematory or Cremator	Y	1		Catonsv	ille,	Maryland
Balt	permit. Depart Import any Inj		21. Signature of Funeral Service Licens	wy C		Z2 Name a Kirkle 42I Ci	nd Addres Ey-Ru Cain	dick Fur Highway	eral Ho	me P.A Len Bur	nie, l	21061 Maryland
760	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ications that caused it in a cause on each line.  a. Due to (or as a composition of the c	consequence	rbstwzt ce of): ce of):	de of dying	1, such as cardiac	n n	rest,		Approximate Interval Bestween Onset and Death
Box 68	eath certifica attending ph for use as th	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal dea	ath 3 ⊟Ect <i>o</i> pic p					ate of delive	ery Day Year
ر م	quires that I	ed by Ph	Part II. Other significant conditions of	entributing to death but	1.10	g in the underlying	cause give	n in Part I.	23e. Did to	/	ntribute to th	ne cause of death?
of Vital Records P.O.	The law recate has bee	Complet	was sure	jically,	upa	ired			24a. Was autop perfo 1 Yes		Were auto prior to cor death? 1 \( \text{Yes}	psy findings available mpletion of cause of 2 No
* 5	ysician is certifii director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: Inpatient	2 🗆 ER/	Outpatient 3 □ D	OA Othe	26. Place of Deat	h <i>(Ch</i> ec <i>k only d</i> ome 5 ☐ Resid		her (Specif	y)
Division		Certification:	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			М		at ? ′es 2 □No	28d. Describe h			il Route Number,
į	ital or At irs after or ral Directed in by	Certif	4 Homicide determined	28e. Place of Injury building, etc.	(Specify)	, farm, street, facto	ry, office		City or Tov	vn, State)	or Hura	i noute Number,
	n 24 hou he Funei bletely fil	edicai		vaicien: To the best of iner: On the basis of e and manner state	xamination							
	Tot	M	29b. Signature and title of certifier	OD ATT	CUB	ING 25	DS	6399		29d. Date sign		
	10		30. Name and address of person who o	AN, MLD	VI	uversit	y Spa	cialty	Hospita	al to	IS.Cl	2004-
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 3 20	32. Registrar	s Signature		-	/	.7			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 06617 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death March **Physician** 1215AM Ellis Rose Marie 2004 /Medical 4a Fecility Neme (If not institution, give street and number) Eity, Town, or Location 4c. County of Dea Examiner Burnie 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Sept. 27 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 F Months Yrs. Director 213-28-9314 73 Maryland Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryler Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notitied at page. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No by Funeral Director MD Anne Arundel Odenton 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 520 Stoney Hill Court 21113 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2XX\o If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. Baltimore, Marylahd 21215-0020 Specify: White 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bishop Mefford Ruth Adreon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara McMickings (Daughter) 1319 Chapelview Drive, Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 3/4 2604 Lakeview Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or comportations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner Si AWREK or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊞Unknown δ cate has been siç r, pega 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 □ Yes 282No 1 ☐ Yes 2 ☑ No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 (X) Naturel 5 Pending after death.

Director: Aft
d in by the fur investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after dea To the Funeral Director complataly filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier Medical 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29b. Signature and title of certifier 3 68 Juse

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State

Registrar

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30. Name end eddress, of person who completed cause of death (Item 23e) (Type, Print)

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32. egistrar's Signatur

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31. Date filed (Month, Phy.

State of Maryland / Department of Health and Mental Hygiene 2006

			For State Registrar	State of Marylar		artment of H			Reg. No.	2004	
-10 g	Physici		1. Decedent's Name (First, Middle, Last Carl	Ferra	ro			2. Date of Dea	Day	Year 27, 200	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give Saint Joseph		nter			son	4c. C	ounty of Death Ba	ltimore
	Funeral Director		213 07 1100	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 11-29-1	y, Year) 1919	9. Birth Con Ita	nplace (State or Foreign untry) y
	a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimor		ty, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28	i Director	10e. Street and Number 3 Dundas Court			10f. Zip Code 21234			10g. Citize	en of What Co	untry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Examinational Le notified at	Completed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Orvorced	12. Was Decedent Ever in L Armed Forces? 1 Wes 2 No If Yes, Give Year or Dates: WW]		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		I. Race - Amer Black, White Specify: W	
Maryland 21215-0036	d within 72 ho giene. r than *natur the Medical I	ompieted	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occupi o kind of work done o DO NOT use retired 10r	durina most of wor	king	16b. Kind	of Business/I	ndustry
yland	should be filed ind Mental Hygie marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Benjamin	Ferraro				ерра		Nespu	
Mar	and 2 sho ealth and n 27 is mu		19a. Informant's Name/Relationship (7) David Ferraro	iype, Print)		ng Address (Street a Eastham R					lip Code)
Baltimore,	Pages 1 ar nent of Hea int: If itam:		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation / 5 Other (Specify	rwanioval irom State		osition (Name of matory or other place Valley Me		3/2/04		ation - City or 1	Fown, State
Balti	permit. Pages Department of I Important: If its any injury or of		21. Sig arm of Funeral Service Lie	th!	Ŕ	นะหา <b>ร</b> ชชช 050 York	h <sup>of</sup> Fullyera	1 Home,	Inc.		
8	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Due to (or as a consector)	AL IN	FARCTION	V	or respiratory ar	rrest,		Approximate Interval Between Onset and Death DAYS YEARS
68760,	death certificate be executed e attending physician and of or use as the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  d	quence of):	1 5 1 200 40 300 5000 7	9 State Sales				C fam ( ) I V bar
P.O. Box 68	death certiff e attending id for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	aldeath 3	□Ectopic pregnancy □ Other (specify)	,		23	d. Date of deli	very Day Year
	luires that signed to lid be det	þ	Part II. Other significant conditions or	ontributing to death but not re	sulting in the u	inderlying cause give	en in Part I.	23e. Did to	_	,	the cause of death?
Il Records,	The law requires that the cate has been signed by the page 2 should be detached.	Completed						24a. Was autop perfo 1 ☐ Yes		24b. Were au prior to d death? 1 🗌 Yes	topsy findings available completion of cause of
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 X Inpatient 2 D	] ER/Outpatie	nt 3 DOA Oth	00	ith <i>(Check only o</i> lome 5 ☐ Resid		☐Other (Spec	elfy)
ion of	Attending Ph ir death. ector: After th by the funeral	tion: T	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	yat k? Yes 2 □ No	28d. Describe h	now injury	occurred	
Division	N or Attendii after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st	reet, factory, office		28f. Location (S City or Tov		Number or Ru	ral Route Number,
	Hospite 24 hours Funeral tely fille	Medical C		ysician: To the best of my kn liner: On the basis of examin and manner stated.							
	To the within 2 To the comple	Me	29b. Signature and title of certifier,	lay.M.D.		29c. License	e number 17695	1	_	signed (Month	27, 2004
	611		30. Name and address of person who o	completed cause of death (Ite	601 0		IVE TOS				
	Sta	ite	MAR 0 3 20		hat A	ack i					

State of Maryland / Department of Health and Mental Hygiene 200406619 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 27 2004 10:00 P <sup>M</sup> Frank J. Faimann /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Parkville Baltimore Oak Crest Care Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X**□M 2□F Yrs. 212-07-5948 96 19,1907 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. It has the marked other then "natural", or items 23e or 28e-f show other traumatic event, I'm Medical Evaluations to marked other traumatic event. 1 ☐ Yes 2 X No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Apt 3219 USA 8800 Walther Blvd. 21234 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **☐)(**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐**X**No white Specify: Specify. ģ 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 V.P. & Accountant Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Faimann Elizabeth Velonosky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20 S. Charles St. Baltimore, Md. 21201 / attorney Jerome Geraghty Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of He
Important: If iter
any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation ☐ Other (Specify)
21. Signature of Furerar Service Licensee Dulaney Valley Mem Gardens 3/3/04 Timonium, MD 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to no each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) eloprolit erative Disorder Physician /Medical Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consultience of: Examiner Due to (or as a consequence of): the attending physician The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, bro vascular 1 ☐ Yes 2 ≝No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 27. Man of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 🗗 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and to of certifie 29/04 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Blvd, Parkrille, 3 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 3 2004 Registrar

10.00pm

Maryland 21215-0036

P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene 2004 06620 AMEND ITEM #20b PER FH G829 3/03/04 Jh Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Augustus Month **Physician** 6:30 AM TARMER 28 2004 EB /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner KEISTENHUN CHERKY WOUD Bothnece Leture Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Social Security Number **Funeral** Days Hours Months M 2□F Ulag Director 5950 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. Stete if Haath and Mentel Hydiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at Yes 2□No BALLIMOR Director MARY/AD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 900 USA 21217 D. Funeral 12. Was Decedent Ever in U,S. Armed Forces? ↓ Serves 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status → Sever Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify: Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Elementery/Secondary (0-12) College (1-4or 5+) Jostal Clerk post affice years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) Be Pages 1 and 2 should be f nent of Haaith and Mentel I DAVIS ELGENIA Ugustus SES5/UNS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type Print) 6201 Western Run DruE Baltraere INIECE Not 21209 KuthA treamon 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Boltinor. CREENMOUNT CEMETERY 22. Name and Address of Facility CNATION - HIMTH FUREN HOME 5240 LENTENSHAN MAD 21. Signature of Juneral Service Licensee MU 21218 23a. Pert / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BAL HOUSE, Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner Physician: The law requires thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 1 765 2 w No 1 ☐ Yes 2 ☐ No erei Director: After this certifici filled in by the funaral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medicai Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Attending 1 Naturei 2 Accident 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours e To the Funerel Complataly filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my entires. 29a. Certifier (Check only one) Medical Exa Iner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifie my tho completed cause of death (Item 23e) (Type, Print) 30. Neme and address 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

MAR 0 3 2004

			State of Maryland / Department of Health and N  State Certificate of Death	Mental Hy	/gien2 0	04	06621
			1. Decedent's Name (First, Middle, Last)	2. Date of D Month		Yeer	3. Time of Death
	Physici /Medi		Joseph Lawrence Fortenbaugh	Febru		2004	11:35AM
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	'	-	ty of Death	
			Franklin Souare itostital Rosedal & Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	9 Date of B	Bal	/	place (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) It Under 1 Year IT Under 24 Hrs. 216 14 3228 7. Age (In yrs. last birthday) Yrs. Months Days Hours Min.	8. Date of B	10 1912	Cour	more Maryland
			Usuel Residence of Decedent	August	10 1012		
	r 28a-f show		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Ba-1 s	cto	Maryland Baltimore Baltimore County				1 ☐ Yes 2 No
	with the	Dire	106. Street and Number  10 Fuller Avenue  21206		10g. Citizen of	What Cou	ntry?
	death with the Maryland ms 23a or 28a-1 show rmust be notified at	Funeral Director	11 Marital Status 12, Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (S)	pecify Yes or N		ace - Ameri	
- "		F	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	BI	ack, White,	
9	rait, o	1 by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Spec	"'y: Whit	e
1050 PM	titled within 72 hours after Hygiene. Hyber than "natural", or Ite ent, the Mcdical Examina	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king	16b. Kind of	Business/In	idustry
ئے جا	within 12 in the name of the n	d E	Elementary/Secondary (0-12) College (1-4or 5+) Accounting		Glenn L.	Merti	n Co.
	be filed within that Hygiene. In other than event, the M	ပို	17. Father's Name (First, Middle, Last)  18. Mother's Nam	ne (First, Middle			
mg.	ild be lentat ked c	To Be	Joseph August Fortenbaugh Johanna H	artman			
enbough	Idf yidild 4.14 2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the Man		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			n, State, Zij	p Code)
$\lesssim$	and 2 and 2 ealth m 27 I		Frances R. Fortenbaugh (Wife) 10 Fuller Avenue Baltimore	The second second			
+	Dallillore, Maryialla bermit. Pages 1 and 2 should be file bepartment of Health and Mental Hy mportant: If tem 27 is marked oth- my njury or other traumatic event more.	Ш	20a. Method of Disposition  1X□ Burial 2 □ Cremation 3 □ Removal from State	Date	20c. Location		
2	t. Partmen		*4 Donation 5 Other (Specify) St Stanislaus Cem. March 4 2004		Baltimor	e,Mary	Tand
W d	DEALITIONE, INITY JIST PROBLEM. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 is marked any injury or other traumatic events.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Lassahn Funeral Home In 7401 Belair Road Balt:	nc imore,Mar	yland 212	236	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition a. Acute PE				Onsot and South
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
		ē	Sequentially list conditions, if any, leading to immediate  b. HEUTP IVI  Due to (or as a consequence of):				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.				
	O, exec an an rrial-tr	Exa	resulting in death) Last  Due to (or as a consequence of):				
1	cate be executed physician and the burial-transit	dical	d				
(	D ∰ Se		IFFEMALE: 23c. If yes, outcome of pregnancy		224 [	Date of deliv	10.01
Ċ	VISION OF VITAI HECOFIAS, P.O. BOX Of Attending Physician: The law requires that the death certific rideath. ector: Affer this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by Physician/M	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy			Month	Day Year
(	that the de led by the a	nysi	1 Yes 2 No 9 Unknown				
•	S, T es that igned b	Y P	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use co		the cause of death?
-	cords, w requires to been signed should be	led		10	Yes 2 No	3 Pro	bably 4 Unknown
	law rates be	Completed		24a. Wa aut	opsy	prior to co	opsy findings available ompletion of cause of
	VITAI KEC siclan: The law s certificate has b lirector, page 2 s	S		1 ☐ Yes	formed? 2/2 No	death?	2 No
	VITC ician ician certifii	Be	25. Was case referred to medical examiner?  Hospital:   Claration   2   Clarat				
1/4 .	on or ding Phys a. After this funeral di	. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		sidence 6 🗆 O		ry)
	On nding th. :: Afte	ation	Image: Property of the prope				
	DIVISION OF VITAL RECORDS, P.O. BOX or Attending Physician: The law requires that the death cer after death.  Director: After this certificate has been signed by the attendir in by the funeral director, page 2 should be detached for use	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To	(Street and Num own, State)	nber or Run	ral Route Number,
(	pital o		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place	, and due to the	e cause(s) and r	manner as	stated.
	DIVISION OF VITAL HOSPITATION OF VITAL HOSPITATION TO THE WITHIN 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only one)  2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurrence)				
	To the To the Complex	Σ	29b. Signature and title of certifier 29c. License number		29d. Date sign	ied (Month,	Day, Year)
	20		Imm raing M Resource		2/2	1100	7
	.70		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Pr. Binh Nowy en 2000 Franklin Square DriveBoltimore	MD 3	11222	/	
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	· *, ·			
	Regis	trar	MAR 0 3 2004 Merene to spende				

State of Maryland / Department of Health and Mental Hygiene 2004 06622 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death **Physician** Month Day Year Walter Ashton Fountain, Jr. February 29 2004 1:40 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 716 Eastshire Drive Catonsville
If Under 1 Year | If Under 24 Hrs. Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1**X**M 2□ F Months Director 220-07-0447 84 01/26/1920 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location **ehow** 10d Inside City Limits Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 X No Baltimore Catonsville Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 716 Eastshire Drive 21228 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 No 2 No 1942 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1942-1945 1 Tyes 2 No Specify þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than eny injury or other traumon. Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanical Engineer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Walter Ashton Fountain, Sr. Marie (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne A. Fountain/Son 716 Eastshire Drive Baltimore, MD 21228 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 □Donation 5 □ Other (Specify) Balto-Wash Crematory 03/04/2004 Laurel, MD 22. Name and Address of Facility
Sterling Ashton Schwab Funeral Home Inc.
736 Edmondson Ave. Baltimore, MD 21228 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that consed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or in tailure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** ONGESTIL hours resulting in death) /Medical Due to (or as a consequence of): Examiner RODARG 4 BARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the all P.O. ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacoo use contribute to the cause of death? 2 Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 PNo Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 esidence 6 Other (Specify) ٩ 2 □ ER/Outpatient 3 □ DOA ot Sill funeral 27. Mannay of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 atural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) de mined 4 Homicide To the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifi-29c. License number 29d. Date signed (Month, Day, Year) D16200 TENdinal Lysician 0 completed cause of death (Item 23a) (Type, Print) 720-C MAIDEN Choice LA J. M. MACHIEAN Mis 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

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Registrar

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State of Maryland / Department of Health and Mental Hygiene 2 06623 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** .0 RUTH KATHLEEN FIELD MARCH 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE TOWSON 204 EAST JOPPA RD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 508-52-4553 6. Sex 7. Age (In yrs. last birthday) IOWA **Funeral** 1 ☐ M 2 🕱 F 6 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No TOWSON Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number EAST JOPPA RD. 2 286 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ATTORNEY GENERAL OFFICE College (1-4or 5+) Elementary/Secondary (0-12) LEGAL SECRETAR of Health and Mental Hygie item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be eq pinous LARSON LENA STEVEN FIELD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importsnt: If item 27 Is n any injury or other traun 204 EAST JOPPA RD, TOWSON MD 21286 IORIN EXECUTOR VIRGINIA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/03/0 ARROLL CREMATION 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO. 21. Signature of Euneral Service Licensee YORK RD MONKTON, MD. 16924 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IVIHOSIS Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1. ☐ Yes 2 ☐ No vombocytopenia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 1 Yes 2 No Medical Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After Injury To the Hospitel or Attending 5 Pendina Natural 1 TYes 2 🗌 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗒 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 033550 104 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2121 3730 Fulls Betsv Dat 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 03

		Please I  1 - State Registrar	State of Maryla	nd / Depa	artme	ent of He ate of D	alth and i	Mental Hy	giene2 (	) () 4	06624
Physic /Medi		1. Decedent's Name (First, Middle, Last)  Mourice	Fader					2. Date of De. Month PEDYUL	Day	2004	3. Time of Death
Exami		4a. Facility Name (If not institution, give s NORTHWEST HOSPITA				ly, Town, or L ANDALL	ocation of Deat STOWN	h		TIMORE	
Funeral Director		5. Social Security Number 6. Sex 214-26-7160		. la <i>st birthd</i> ay) 92 Yrs.	If Und Month		If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da AUG . 12	, 1911	9. Birthple Countr	ece (State or Foreign ry) MD
aryland show	_	Usual Residence of Decedent  10a. State 10b. County		ity, Town or Lo						10	d. Inside City Limits 1 ☐ Yes 2 ☑ No
h the Mi or 28a-f	Funeral Director	MD BALTI  10e. Street and Number	MURE	PIKI	ESVI 10f. 2	LLE Zip Code			10g. Citizen o	of What Countr	
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CLIZIS-UUSO filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-1 show snt, the Medical Examiner must be notitled at	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☼ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		_	pecify Cuban,	Mexican, Puerl	pecify Yes or No o Rican, etc.)	Spec	llack, White, e	
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d be ental	To Be C	17. Father's Name (First, Middle, Last) BENJAMIN		FADI	ΞR	1	8. Mother's Nar GERTRU	ne (First, Middle, DE	, Maiden Sum		FELDBLUM
re, Maryl s 1 and 2 shoul f Health and M item 27 is merl other traumeti		19a. Informant's Name/Relationship (Ty) JERRY FADER / SON	oe, Print)					ıral Route Numbe BALTI –			
0 0 -	-	20a. Method of Disposition  1 🕅 Burial 2 🗀 Cremation 3 🗆 R		Place of Dispo cemetery, crei	sition (A	lame of	Ţ	Date		n - City or Tow	
Pa Part Land		'4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Liperise	BA		_		EM. 3/2			TERSTO	-
Dermit. Departi		Say Way	lu-			REIST		OL LEVIN ROAD =			MD 21208
Physician /Medical Examiner		23a. Part . Inter le disease, o pli sho > or h in failure. List inty or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deale cause on each line.  Due to (or as a conse	quence of):	or the m		such as cardiad	c or respiratory a	rrest,	11.1	Approximate Interval Between Onset and Death
8 / 60, ate be executed thysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):							
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dS, P.O. I uires that the de isigned by the a ld be detached f	by	Part II. Other significant conditions con	stributing to death but not re	sulting in the u	nderlyin	g cause given	in Part I.		obacco use co Yes 2 □ No		cause of death?
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Of Vita Phyaician: rthis certifica ral director,	o Be	25. Was case referred to medical examiner?	lospital:	- WOutpatier	at 2	DOA Other	- CONT.	ath <i>(Check only o</i>		Other (Coosie)	
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7		Do lamento	Man			HOOS	1551		ebri	rary o	29,2004
10		30. Name and address of person who co	mpleted cause of death (Ite 22 Registrat's Sign	Old Ct.	Print	1. Kell	Idaliste	own W	D 2	1133	
S Regis	tate trar	MAR 0.3 200	32 Registrar's Sign	M. A.	as a Re	B					

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State Registrar	State o	f Marylar	nd / Depa <i>Cei</i>	artment <i>tificate</i>	of H	lealth a Death	and M		iene •g. No.		4 (	06625
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200000	Physicia /Medica		Erma M. Genson								Februar			1	0:00 A <sup>M</sup>
	Examine		4a. Facility Name (If not institution, gi	ve street and nur	mber)		4b. City, 1	Fown, or	Location	of Death			County of De		
	. \$ \$	Ç.,	Gilcrest Hospic					ows		041110			ltimo		(0)
	Funeral Director		5. Social Security Number 6. 214-24-2513	Sex 1□M 2 <b>Z</b> F	7. Age (In yrs. 92	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day 7/3/	Year) 1911	9. 5	Country) MD	State or Foreign
1000 Maryland	>	<b>)</b>	Usual Residence of Decedent  10a, State 10b, County		10c Ci	ty, Town or Lo	cation							10d. lr	side City Limits
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eath	ns 23	Funeral	6336 Cedar La. A	12. Was Dece	edent Ever in U	J.S. 13.1	Was Deced	210 ent of H		igin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - Ar	nerican In	dian,
frer de	I Item	들	1 ☐ Never Married 2 ☐ Married	Armed Fo	rces? 2 No			,			Rican, etc.)		Black, W	nite, etc.	
38 g	o', e	þ	3 Widowed 4 □ Divorced	If Yes, Giv Year or D	ve ates:		1 ☐ Yes 2	No No	Specify:				Specify: W	hite	
1215-0036 Within 72 hours after death with the Maryland	Department of Health and Mental Hygiene important; or Items 23a or 28a-f show important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, it a Neutsal Exameter must be notified at once.	Completed	15. Decedent's l	Education		16a. Deced	dent's Usua kind of wor	l Occup	ation	t of worki	ina	16b. Ki	nd of Busine:	ss/Industry	1
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\$ <b>a</b> &	is m		19a. Informant's Name/Relationship				•				a <i>l Route Numb</i> e lersburg				9)
1 and	Health Iem 27	1	Louis F. Genson  20a. Method of Disposition	– Son	20b.								cation - City		State
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	Department Important: any injury once.	4	*4 □ Donation 5 □ Other (Spec 21, Signature of Funeral Service Lic		WC	odlawn					zke Fun		-		latons-
Bal	Depa Impo any ii		21. Signature of Pulloral Solvice and	7/	w/	-					on Ave.				
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Division of Vital Records, P.O. Box 68 or Attanding Physician: The law requires that the death certifica	ed by the attending ph detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		birth 2 ☐ Fet nant at time of	al death 3[	Ectopic pro		<u>'</u>				23d. Date of o Month	delivery Day	Year
P. hat th	igned by t be detach	Ph	Part II, Other significant conditions	contributing to d	leath but not re	sulting in the u	nderlying c	ause div	en in Part	l.	23e. Did to	bacco u	ise contribute	to the car	use of death?
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ital	s certificate has b	Bec	25. Was case referred to medical						26. Plac	e of Death	h (Check only or	10)			
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O LC	After th funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigat		of Injury oth, Day Year)	28b. Time o Injury	f 2	8c. Injur Wor	yat k? Yes 2□		28d. Describe h	ow injur	y occurred		
Division at or Attending	within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Certification:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place	e of Injury - At I ling, etc. (Spec	nome, farm, sti					28f. Location (S City or Tow	treet an n. State	d Number or )	Rural Rou	ite Number,
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			Alcon		VVD			D S	750	3	f	els	wary 2	770	04
	V		30. Name and address of person who		- 1.	em 23a) (Type,	Print)	ples	4	Bulh	more h	12	21204		
	Sta Registra	-	31. Date filed (Many) Pay Year) 2	004	Registrar's Sign	nature	and a								

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06626 Certificate of Death AMEND ITEM #5 PER FH G829 3/17/04 JH Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** February
4b. City, Town, or Location of Death avetta Goldman 28 9:50 Am 2004 /Medical 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner LORIEN NURSING HOME & REHAB CENTER BEL AIR If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral 2<del>15-05-59</del>84 Months Days Hours 1□ M 2□ F Director NOV.14,1921 PA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County parmit. Pegas 1 end 2 should be filed within 72 hours efter deeth with the Maryle Department of Heelith end Mantel Hygiana. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show the Injury or other freumatic event, the Medical Examiner must be notified at pine. 1 ☐ Yes 2 ☐ No Funeral Director HARFORD ABINGDON 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 3404 TULLEYS POINT COURT #1-C 21009 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💢 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: WHITE Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) MANAGER RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) **JOSEPH** DIAMOND EVA **FORMAN** 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROCHELLE BELLMAN / DAUGHTER 902-G JESSICAS LANE - BEL AIR, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. SHARON CEMETERY 3/2/04 SPRINGFIELD, PA 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical METASTATIC CARCINOMA Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificeta be exacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initleted events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No HYPERCALCEMIA, ANEMIA, HYPERTENSION, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed CORONARY ARTERY DISEASE 1. Yes 2 K No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 20 No 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 3 DOA edicai Certification: To within 24 hours after death.

To the Funeral Director: After this completaly filled in by the funaral di 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Decrtifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 45344 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) UNION AVE, HAURE DEGRACE, MD 21078 DHANJANI ,6225.

**DHMH 16 Rev 6/95** 

State Registrar MD

2. Registrar's Signature

, Year) 3 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HOERNLEIN **Physician** EVELYN MARCH 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW BALTIMUNE CITY Under 1 Year | If Under 24 Hrs. | onths | Days | Hours | Min. | 8. Date of Birth (Month, Day, Yo April 20, Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1920 **Funeral** 1 ☐ M 2 🗙 F 83 Months 217-12-3366 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7401 Waymouth Way 21222 United States Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2X Married 0 Maryland 21215-0036 byr 1 ☐ Yes 2 ☑ No Specify White Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. itam 27 is marked other than 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Oscar Ritenour Grace Cavey 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Hoernlein - Husband 7401 Waymouth Way Baltimore, Maryland 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If italiany injury or oth Sacred Heart of Jesus Cemetery 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/4/04 Dundalk, Maryland permit. 21. Signature of Fune at Sen 22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Road Dundalk, Maryland 21222 2134 Willow Spring Road Dunct 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRYTHMIA **Physician** MINUTES /Medical Due to (or as a consequence of): Examiner FAILURE DESPINATIONY WEEKS HAUNIC Sequentially list conditions, for a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for as a consequence of Examiner death certificate be executed MALNUTRITION SEVENE the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical ALZHEIMERS ADVANCED use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? for Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. I detached he δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by page 2 should be PNEUMONIA, ANEMIA, CUMUNARY 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? (es 20 No certificate 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of After Hospital or Attending Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funaral Diractor: A 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D00524.68 03/01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMUNE EDWARD CHEN, MD 4940 BASTERW AVENUE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 0 3 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06628 For State Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2:07 A M February 27 2004 Thomas Hughes 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore
If Under 1 Year If Under 24 Hrs. N/A University of Maryland Medical Center
5. Social Security Number 6. Sex 7. Age In vrs. last birthd 9. Birthplace (State or Foreign Country) 212-34-7975 10M 2 F Days Hours Mary lana Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b County 10d. tnside City Limits 1 Des 2 No Iha Battimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 917 21205 Ken wood USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 █ No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) alesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hughes Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, md. 21205 Kenwood 20b. Place of Disposition (Name of Date 1 Burial 2 ☐ Cremation 3 Removal from State MT. Carnel Cen \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 108 W. North Ave. Batto 23a. Part1. Enter the disease, or complications that cursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Myocardial Infarction Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death
4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner?
1 ✓ Yes 2 □ No 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier

To the Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-tran attending physician and Division of Vital Records, P.O. Box 68760, s been signed by the certificate After this neral Director: After thi within 24 hours a

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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permit. Page Department c important: If eny injury or once. injury or

**Physician** 

/Medical

**Examiner** 

Examiner

Physician/Medical

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Medical Certification:

Pages 1

Director

Funeral

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Completed

with the Maryland

1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

MAR 0 3 2004

29b. Signature and titte of certifier

DEAN W.

31. Date filed (Month, Day, Year)

MEADOWS 22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOUTH GREENE ST 32. Registrar's Signature

29c. License number

P1648

29d. Date signed (Month, Day, Year)

Baltimore, MD 212

February 27, 2004

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06629 For State Registrar Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 1330 2004 Lillian Gwendolyn Herbert /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita Ci in Baltimore Baltimore Sina 01 Under 1 Year | If Under 24 Hrs. 8. Date of Birth NOV. 9, 1906 6. Sex Birthplece (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days Min. 1 □ M 2 X F 97 Months Hours MD Director 217-05-4633 Usual Residence of Decedent 10a, State 10b, County 10c. City. Town or Location 10d. Inside City Limits r Items 23s or 28s-1 show tiner wast be notified at 1 XYes 2 No N/A Baltimore Director the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4202 Maine Avenue Completed by Funeral 21214 U.S.A 14. Rece - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify:Black 3

Widowed 4 □ Divorced "natural" is marked other than "nature aumatic event, the Modical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation USFand G Insurance (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Company 12th Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Handy Bertha Jackson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lizzie Linton - Social Worker 1000 Cathederal St. MD 21201 Important: If Itam 27 any injury or other tr Balto., Baltimore, 20b. Place of Disposition (Name of 20a Method of Disposition Date 20c. Location - City or Town, State Pages 1 Burial 2 □ Cremation 3 □ Removal from State New Cathedral Cem. 3/6/04 BAlto., MD ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, 21. Signature of Funeral Service Licensee Eme 2501 Gwynns Falls Pkwy.

23a. Part . Enter the .sease, or complications the ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 2501 Gwynns Falls Pkwy. Balto., Immediate Cause (Final embolus **Physician** Palmonar resulting in death) /Medical Oue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 X No 2 X No 1 Yes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this After thi 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred Certification: 5 Pendina 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: d in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, streel, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide ŏ within 24 hours at To the Funeral Di completely filled in To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number -900 and address of person who completed cause of death (Item 23a) (Type, Print) West Belvedere Avenue, Baldinore M.D 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

Herbert, Gwendolyn

05:

KNOWN

P.O.

3 2004

State of Maryland / Department of Health and Mental Hygiene 2004 06630 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 02 Day **Physician** Year HOWARD THOMAS HOWE 29 2004 12:40 AM /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Death Examiner BALTIMURE VA MEdiCAL CENTER MALtimore If Under 24 Hrs. 5. Social Security Number if Under 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 213-28-1563 11 M 2□ F Yrs. Director 29 1930 Dec. Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 ia marked other than "natural" --- any injury or other traumatic average. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Funeral Director Md. Anne Arundel Co. Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 514 Taney Avenue 21225 U.S.A. 11. Meritel Status Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Guard New Car Dealer 0 unknw. 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Howe Sr. Thomas Mary Feelev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) John J. Calvert Jr. 514 Taney Ave. Baltimore, Md. 21225 (Son) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🎧 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Memorial Pk. 3702/04 Glen Burnie, Md. 21. Signature of Fundral Service Licensee Kevin E. Ecker 22. Name and Address of Facility
McCully-Polyniak Funeral Home p.A 237 E. Patapsco Ave. Baltimore, Md. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examine certificate has been signed by the attending physician end irector, page 2 should be detached for use es the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 Probably 4 Unknown 2 Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 L Yes 26/110 1 ☐ Yes 2 No : After this certifica e funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1' Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending s after death.

I Director: Aff
od in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directornial of the Completely filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 17643 MD. 30. Name end ad thiss of person who completed cause of death (Item 23e) (Type, Print) CREENE STREET BALTIMORE, MD21301 WEN-YEE TSAI 31. Date filed (Month, Day, Year) 32, Registrer's Signature State

Registrar

MAR 03

* /		1 - State Registrar  1. Decedent's Name (First, Middle, Last)	State of Maryla	nd / Departm	ent of Health and cate of Death	2. Date of Death	ne 2004 0663
Physicia /Medica Examine	al	JUSTIN K 4a. Facility Name (If not institution, give Greater Baltimo:	re Medical	Center	City, Town, or Location of De $Towson$		4c. County of Death Baltimore
Funeral Director		5. Social Security Number 6. Security Number 1	7. Age (In yrs	. last birthday) If U Yrs. Mon	ths Days Hours Mi	n. (Month, Day, Ye	9. Birthplace (State or Foreign Country)  Many No.
he Maryland	Director	Manylon & 10b. County		ity, Town or Location  REST	4:11		10d. Inside City Limits 1 ☐ Yes 250 No
filed within 72 hours after death with the Maryland Hyglene. Then "natural", or items 23a or 28a-f ehow ont, it a Medical Examinar must be notified at on.	Funerai Dir	10e. Street and Number  2/1/8 MAR J  11. Marital Status	DRIV  12. Was Decedent Ever in U	re	ZID Code  21050 ecedent of Hispanic Origin? specify Cuban, Mexican, Pue		Citizen of What Country?  USP  14. Race - American Indian,
hours after tural, or ite	рý	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	1 □ Y€	s 2 No Specity:		Black, White, etc.  Specify: White
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Pages 1 and 2 st nent of Health and int: If item 27 is n iry or other traun		19a. Informant's Name/Relationship (Ty, C. B. P. T. H. C. 20a. Method of Disposition 1 Burial 2 Command 3 R	20b.	Q70/ Q/ Place of Disposition cemetery, crematory	(Name of or other place)	Tousa	
permit. Pages 1 a Department of Hea Important: if item eny injury or othe once.		21. Signature of Funeral Service License	010	2	and Address of Facility  Variety On Man	tensy W Je	NEWS + SEAS CO.
Physician /Medical Examiner	10	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	Due to (or as a consection)	Prema ha	,	ac or respiratory arrest,	Approximate Interval Between Onset and Death
ficate be executed physician and sthe burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate any and the first cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	chit &			
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fett 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 Ectop	c pregnancy (specify)		23d. Date of delivery Month Day Year
requires that the	ן הַ	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlying	ng cause given in Part I.	23e. Did tobacc	ouse contribute to the cause of death?  2 □ No 3 □ Probably 4  □ Unknown
The la ate has page 2	Completed					24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
F E E	ation; to be	25. Was case referred to medical examiner?  1	ospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Other	eath Check only one)  Home 5 TResidence 28d. Describe how in	
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: Alter completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	(y) 		City or Town, St	
To the Hospital or within 24 hours after to the Funeral Dir. completely filled in 1	Medical	29a. Certifier  (Check only one)  29b. Signature and ditte of certifier	er: On the basis of examina and manner stated.	owledge, death occur ation and/or investigat	red at the time, date and plaction, in my opinion, death occurred.	urred at the time, date a	and place, and due to the cause(s)
F 3 F 3		1 60 mu	w				Date signed (Month, Day, Year)  2 20 (CL)
State		30. Name and address of person who con Robert E. Ottewn 31. Date filed (Month, Day, Year)  MAR 0.3 2004	npleted cause of death (Iter 1 Hen, M.D., 32. Registrar's Signa	n 23a) (Type, Print)  LSGS N ature	D31277 1. Ohules S	t., Bolt.	md. 21204

ORIGINAL

HASLUP, BADY B MELLSAF

			State of Maryland / Department of Health and I  State  Certificate of Death			06632
	-		Decedent's Name (First, Middle, Last)	2. Date of Dea	ith Dey Yeer	3. Time of Death
	Physici /Medi		Viola Hazelton	2	270	1130 AM
4	Examir	ier	4a. Facility Name (If not institution, give street and number)  Caton Mandy Nursing Home  4b. City, Town, or Location of Death  Catons VI	ile	4c. County of Deeth	imore
	Funeral		5. Social Security Number 6. Sex 7. Age (Ihrys. last birthday) If Under 1 Year If Under 24 Hrs.  7. Age (Ihrys. last birthday) If Under 1 Year If Under 24 Hrs.  7. Age (Ihrys. last birthday) If Under 1 Year If Under 24 Hrs.  7. Age (Ihrys. last birthday) If Under 1 Year If Under 24 Hrs.		9. Birth	plece (State or Foreign intry)
	Director		Usual Residence of Decedent	1114	29	GA
	farylan show	5	MD 10b. County 10c. City, Town or Location Baltimore			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
1_	death with the Maryland rms 23e or 28s-f show	Funeral Director	10e. Street and Number 10f. Zip Code	- 1	10g. Citizen of What Cou	intry?
T	s 23e c	eralD	2605 PTerpont Street 21230  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		14. Race - Amer	ican Indian
70/	hours after death with the Marylan Lural; or Items 23e or 28s-1 show Il Examiner must be malified at	by Fune	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert In Yes, Give If Yes, Give In Yes, Give I	to Rican, etc.)	Black, White	
		eted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work)	rking	16b. Kind of Business/li	ndustry
0	be filed within 72 hatal Hygiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)		DOME	STIC
P	an y allow a filed within and Mental Hygiene. Is marked other then aumatic event, the Mental Mental Aumatic event, the Men	To Be C	17. Father's Name (First, Middle, Last)  18. Mother's Nam  First  First	me (First, Middle,	Maiden Sumame)  DDn EV	
J. J. San	Te, Inica yida s 1 and 2 should i f Health and Men tem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru  Evgene A. Hazelton/Son Tabl Turquoise	~	r, City or Town, State, Zi	
1/2	s 1 and of Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name of	Drive	20c. Location - City or T	own, State
A.E.			1 Debunal 2 Cremation 3 Hemoval from State Lina Memorial Park 3	14/04	Randalis	town MD
1	permit. Page Department ( Important: If any Injury or once.		21. Signality of Funered Service Licensae  22. Name and Address of Facility VQ  5151 Baltimore	vations	: Greene Fu i Dive Balfin	neral service
	1 1		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			4 WEEKS
	Examiner		OUE TO (or as a consequence of):	YLCBR	-	3 MON THS
	ed sit	Examiner	Sequentially list conditions, it as y leading to armediate cause. Enter Underlying Cause (Disease or injury			
c	of CC,	Exan	that inflated events c. resulting in death) Last Due to (or as a consequence of):	· · · · · · · · · · · · · · · · · · ·		
09283	cate be physici	dlcai	d			
A >0	eath certific	an/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deliv	
	that the death cer ed by the attendir detached for use	hysicia	in the past 12 months?  1   Yes   2   No   9   Unknown   9   Unknown   1   1   1   1   1   1   1   1   1		Month	Day Year
Od Vital Becords D	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending p completely filled in by the tuneral director, page 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  STATUS POST CERREDUASCULAR ACCIDE.		bacco use contribute to	
	e law req has been	plete		24a. Was a autop:	sv prior to co	opsy findings available ompletion of cause of
<u> </u>	vicion: The lav icion: The lav certificate has	Con	25. Was case referred to medical 26. Place of Dea		2 2 Yes	2□ No
5	Physicia this certi	To Be	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Aursing H	ath <i>(Check only or</i> Iome 5□ Resid	ence 6 Other (Spec	fy)
	ding Pl	tlon:	27. Manner of Death  1	28d. Describe h	ow injury occurred	
⊗ disign	To the Hospital or Attanding Physician: Within 24 hours after death. To the Funaral Director: After this certific completely filled in by the tuneral director.	Certification:	2 Accident investigation  3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Town	treet and Number or Rui n, State)	al Route Number,
_	spital o		29a. Certifier 112 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place	a, and due to the c	ause(s) and manner as	stated.
	To the Hospital. within 24 hours a To the Funaral I completely filled i	Medical	(Check only a Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurrence)  and manner stated.	irred at the time, o	fate and place, and due	o the cause(s)
	To To con	2	29b. Signature and title of certifier  Colored Doole  29c. License number  29c. License number	4   '	2 02 200	. реу, теаг) <b>Ц</b>
	×		JUGNEM Attending Doctor D216+  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  CV-CYRIAC-MO 8021 RITCHIE WWY, PASKNOW  31. Date filed (Month, Day, Year)  32. Registrar's Signature	RVA (	40 21122	
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Regist	el	MAR 0 3 2004			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 06633 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2004 February **Physician** 7:30 A M Lucille Hailey Sarah /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) **Examiner** Baltimore Co. Genesis Heritage Meridian Care Ctr. Dundalk If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖫 F 88 215-24-3018 June 14,1915 Director Virginia Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Dundalk Directo Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 United States 6552 St. Helena Avenue Funerai 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3₺ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Beautician Cosmetology 7 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event size. Be Virginia Taylor Melvin Faris 19a. Informant's Name/Relationship (Type, Print)Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia F. Karczewski 2403 Medonne Meadows Ct.

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date Street, Maryland 21154 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State 2/27/2004 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service, Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 17 Wise Ave. Dundalk, Maryland 21222 23a. Part . Enter the dis-ase, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CEREBRO VASUCAR Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** ONGEST, UE Savientially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit PERTENSION attending physician and Due to (or as a consequence of): BLEEDING Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ò Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by ta should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Dunknown 1 Tes 2 🗆 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 27 No 24a. Was an certificate has 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manne eath 28b. Time of 28d. Describe how injury occurred After Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature apetitle of certifier 30. Name and address of person who comple ed c use of death (Item 2 a (Type, Print) ULL 31. Date filed (Month. 32. Registrar's Signature State • Registrar

DHMH 17 Rev 1/2001

MAR 0 3 2004

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 i.

			1 = For State Registrar	State of Maryland	Certificate of Death		ene2004 06634
TF	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year / // / O
,	/Medic	al	4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location	FEB. 3	28 209 11:15 PM 4c. County of Death
	Examin	er	11	HEALTH N. H	1	MORE	NIA
	Funeral		5. Social Security Number 6. Sex		t birthday) If Under 1 Year If Under Yrs. Months Days Hours	Min. (Month, Qay, X	
	Director		Usual Residence of Decedent		TIS.	AUG. 28,	1929 MARYLAND
	ryland how	<b>.</b>	10a. State 10b. County	10c. City, 1	own or Location	0	10d. Inside City Limits
	Ba-f s	Director	MARYLAND N	IA		ORE CITY	1 ☑ Yes 2 ☐ No
	death with the Maryland ms 23e or 28a-f show	Dir	10e. Street and Number	RD STREE	10f. Zip Code	229 /09	. Citizen of What Country?
		Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	igin? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.
036	hours after death with the Marylar tural', or items 23e or 28a-f show al Examinat man be rediffed at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2⊠ No Specify.		Specify: BLACK
9500-612	ž = =	eted	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Usual Occupation (Give kind of work done during mos	st of working	b. Kind of Business/Industry
121	withii ene. then	Completed by	Elementary/Secondary (0·12) 9 + HGRADE	College (1-4or 5+)	PAINTER		ELF-EMPLOYED
Bu	be filed tal Hygie d other event,	Be C	17. Father's Name (First, Middle, Last)			er's Name (First, Middle, Ma	
ylan	should to nd Ment marked smatic	To	HERBERT	1-0		ADYS	JOHNSON
Z Z	d 2 7 ls		19a. Informant's Name/Relationship (Ty)  ANGELA JOHN:	SON (NEICE)	19b. Mailing Address (Street and Numb	er or Hural House Number, C	ity or Town, State, Zip Code) TIHOLE MD 2/229
ē,	es 1 an of Heall f item 2 r othar		20a. Method of Disposition	20b. Plac	e of Disposition (Name of etery, crematory or other place)	Date/ 20	c. Location - City or Town, State
Ē			1/2 Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	emoval from State	ZION CEMETERY	13-05-04 1	ANSDOWNE, MD.
Battimor	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service License	u Mamo	22. Name and Address of facility	BROWN DIE	R. FUNERAL HOME BALTO. MD 21217
r			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death.	Do not enter the mode of dying, such as		
	Physician		Immediate Cause (Final disease or condition	METASTAT ]	IC (A Upper 8	xt:	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequen	ice of):		
	9 - 9 m	Jer	Saquentially list conditions, if any, leading to immediate	Due to (or as a consequen	ice of):		
	acuted nd transit	Examiner	Saquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
ρĊ,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a consequen	ice of):		
98/90	ificate g phys as the	edical					
XO2	leath certifi attending I I for use as	an/M	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de			23d. Date of delivery
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of deati 9□Unknown	h 5 Other (specify)		Month Day Year
, v	s that gned b	by Pr	Part II. Other significant conditions con	tributing to death but not resulting	ng in the underlying cause given in Part I	. 23e. Did tobac	co use contribute to the cause of death?
ecords,	w requires that been signed E should be deta	ted				1 ☐ Yes	2 No 3 Probably 4 DURKnown
ပို	has bu	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
Vitai	T ate	e Co	25. Was case referred to medical		00 81	1 ☐ Yes	No 1 Yes 2 No
	Physician: r this certific ral director,	To B	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER	Other	of Death (Check only one) ursing Home 5 🗆 Residence	e 6 ☐Other (Specify)
n or	gn enth		27. Manner of Death 1,☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	b. Time of 28c. Injury at Injury Work?	28d. Describe how	
UIVISION	eatt or:	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Injury - At home	M 1 Yes 2		at and Number or Rural Route Number,
2	i ji te o	Certification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)		City or Town, S	State)
	To the Hospitat within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinate)	ician: To the best of my knowle er: On the basis of examination and manner stated.	dge, death occurred at the time, date an and/or investigation, in my opinion, dea	nd place, and due to the caus oth occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
	0		P(M(MI)		N) A A	TLT	3/2/04
	2		30. Name and address of person who co	mpleted cause of death (Item 23	109 Such live	well to	3/2/04 and MD21221
۲	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Carles		

			For Amend Item 10e I	erState of Marylar	g/dhepar	tment of H	lealth and	Mental Hy	/giene	2001	0660
			1 - State Registrar  1. Decedent's Name (First, Middle, La		Cert	ificate of I	Death	2. Date of D	Reg. No.	2004	06535 3. Time of Death
	Physici		T. Decedent's Name (Pirst, Middle, La	3 Jacks	m s	30.		Month 02 -	. Day	-2004	6.450M
, :	/Medic Examin		4a. Facility Name (If not institution, giv				r Location of Deat			County of Death	
	类		Stella Maris	at Mercy	Hosp		Himon	ا			
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.		Months Days	If Under 24 Hrs Hours Min.	8. Date of B	irth ay Year	9. Birthpi Coun	lace (State or Foreign try)
le .	Director		Usual Residence of Decedent	700				010	///		1110
	anylan	١	10a. State 10b. County	10c. Ci	ty, Town or Loca					10	0d. Inside City Limits
	28a-f	ecto	10e, Street and Number	<i>A</i>	Dairt	nore			10a Citiz	en of What Coun	
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importent: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at 2006.	Funeral Director	A	runah Avenue			1216		, rog. O	USA	•
	ems 2	ner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. W.	as Decedent of H	lispanic Origin? (S an, Mexican, Puer	pecify Yes or N to Rican, etc.)	0- 1	4. Race - Americ Black, White,	
36	or h	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No		Yes 2 No	_				lack
8	2 hour	ted b	15. Decedent's E		16a. Decede	nt's Usual Occup	ation		16b. Kin	nd of Business/Inc	
21215-0036	thin 7:	Completed	(Specify only highest gra	College (1-4or 5+)			during most of wo	rking 1	111	. )	-1. 1-
2	iled wi tygien her th		17. Father's Name (First, Middle, Last		Ma	chine	18. Mother's Nar	COTOV	Maidan	Strane)	cleatric
anc	d be fi	To Be	James W.	Jackson			Mac	4 00		Smil	-6
Maryland	should and Men marke umatic	F	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing	Address (Street	and Number or Re	Route Num		Town, State, Zip	Code)
	and 2 ealth a n 27 is		Mary A. Jac	Kson (wife	253		nah f	6,4	30017		
Baltimore,	Peges 1 nent of He int: If iter		20a. Method of Disposition  1 Burial 2 Cremation 3		Place of Disposit cemetery, crema	tion (Name of story or other place		Date	-	cation - City or To	
E	it. Pe irtmen irtent: njury		* 4 ☐ Donation 5 ☐ Other (Special 21. Signature Funeral Service Lices		)ruid	Rama and Address	ss of Facility	23/64	100	2 Himore	Service
Ba	permit. Departrimporte any inje	ě,	Jawa C	Du	41	Value	ss of Facility C	Ane.	Bal	to mD	21229
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		scleroti	c Cw	diovasc-	lar D	Seus	1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse	quence of).						
	cuted	Examiner	Cause (Disease or injury that initiated events	c.							
760,	le be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a conse	quence of):						
6876	physic physic the p	dlcai		d	<u>.</u>						
οχ θ	certifi nding use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn					2	3d. Date of delive	ry
. Box	death e atte	icla	in the past 12 months?	1 Live birth 2 Fet. 4 Pregnant at time of a		ctopic pregnancy Other (specify)	′			Month	Day Year
P.O.	at the	Phys	9 Unknown					an Did			e cause of death?
	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	d by	Part II. Other significant conditions of	contributing to death but not re-	suiting in the und	ieriying cause giv	en in Parti.		Yes 2	_	
COL	w requ	letec			-	,		24a. Wa			osy findings available
Re	The lay te has age 2	Completed						auto	ormed2 2 No	prior to con death? 1 \(\sum \text{Yes}\)	npletion of cause of
Vital Records,		Be C	25. Was case referred to medical examiner?				26. Place of Dea		/	- 12,103	1
		2	1 ☐ Yes 2 ☐ No		ER/Outpatient		4 🗆 Nursing r	lome 5 ☐ Res		ther (Specify	אוקכרו
uo Ou	ding h. Atter funer	tlon	27. Manner of Death  1 Natural 5 Pending  2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World	yat k? Yes 2 □ No	28d. Describe	now injury	occurred	
Division of	Atten r deat ector: by the	ifica	2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of Injury - At h	nome, farm, stree	_				Number or Rura	Route Number,
ă	rs afte at Dire ed in t	Certification:	4   Fromicide	building, etc. (Spec	·iy)			City or To	own, State)		
	To the Hospitet or Attending Pr within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	edical	(Check only 2 Medical Exa	nysician: To the best of my kn niner: On the basis of examin	owledge, death o ation and/or inve	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	and due to the	cause(s) a	and manner as sta place, and due to	ated. the cause(s)
	thin 2 o the	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date	signed (Month, L	Day, Year)
	F ≥ F 8		De Am	<b>^</b> -		70	10854			12/200	
	1.9		30. Name and address of person who	1	m 23a) (Type, Pr	rint)		- 3.	2.25		
				ebers 301		Paul PI-	13,140	mere oct	202		
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 3 20	32 Registrar's Sign	ature	A. I					

		4	For State Registrar	State of Maryla	and / Depa <i>Cer</i>	irtment of He tificate of D	ealth and IV Death	ientai Hygi Re	a. No. 200 f	06637		
ĸ.	3 - N.		1. Decedent's Name (First, Middle, Last)  Teresa  Ann					2. Date of Death Month	Day Year	3. Time of Death		
1	Physicia /Medic					Lee		February	28 2004	2150 M		
	Examin	- 4	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or I	Location of Death		4c. County of De	ath		
		7.	Anne Arundel Med			Annapo	lis If Linder 24 Hrs	9 Date of Righ	Anne Aru			
	Funeral		5. Social Security Number 6. Se 216–40–1536	M 2X F 7. Age (in yi	rs. last birthday) 1 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Nov. 17	1942 No	nthplace (State or Foreign Country) orth Carolina		
	Director		Usual Residence of Decedent					1100 - 17	1542 110	oren carorina		
	yland yland		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits		
	a-f st	ctor	MD Anne Aru	ındel A	rno1d					1 Yes 2X No		
	ith the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?		
	23a	rai	400 Century Vist			21012		anifu Van as Na	USA	nerican Indian,		
	er de	Funerai	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2XXNo		Was Decedent of His f Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, Wh	ite, etc.		
36	within 72 hours affer death with the Maryland ane. than "natural", or Items 23a or 28a-f show Ita Majical Exercites mast be natified at	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes XXNo	Specify:		Specify: V	Thite		
21215-0036	2 hou		15. Decedent's Ed	ucation	16a. Deced	dent's Usual Occupa kind of work done di	tion		16b. Kind of Busines	s/Industry		
215	hin 7.	pie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	aring most or work	g				
S	filed wit Hygiene ther the	Completed	12		Manager				Restaurar	nt		
nd	be filed stal Hygi of other event, I	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, N				
yla	should be ind Mental marked o	္	Glenn M. Billing		405 14-17-	- A dd (Ctroot o		M. Darli	Ington City or Town, State	Zin Code)		
Maryland	12 sho		19a. Informant's Name/Relationship (19a. Ben Lee (Husband						Ld, MD 210			
	1 and Health	. 8	20a. Method of Disposition		The Control of Company of the	esition (Name of matory or other place			20c. Location - City of			
Baltimore,	ages nf of l		1 X Burial 2 ☐ Cremation 3 ☐	Hemovai from State		natory or other place of Sorrov		/2004 V	Vest River	· MD		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event. If a Neulcal Examination and once.		*4 □ Donation 5 □ Other (Specify 21. Signature of Eugeral/Septice Licen	3.4						, rib		
	Dep Imp any		Datel A	all		1 Home, P.A. ue, Annapolis, MD 21401						
	Physician		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the d	eath. Do not ent					Approximate Interval Between Onset and Death		
			Immediate Cause (Final disease or condition Arroxic encephalogother									
	/Medical	ÿ.	resulting in death)  Due to (or as a consequence of):							>700-1		
45	Examiner		Sequentially list conditions.	b. corcho	pulma	one y o	rest					
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con-		0.	+/.		77doy			
	and and I-tran	Examin	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									
68760,	icate be execufed physician and s the burial-transit	a E										
687		edical		u.								
Вох	death certifi e affending I ad for use as	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		Ectopic pregnancy			23d. Date of d			
	0 0 0	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time		Other (specify)			Month	Day Year		
P.0	The law requires that the de ate has been signed by the a bage 2 should be defached	Physician/M	9 Unknown				a in Dark I	23a Did tol	acco use contribute	to the cause of death?		
Ś	res fha igned be def	þ	Part II. Other significant conditions of	contributing to death but not	resulting in the u	inderlying cause give	en in rait i.	1 □ Ye		Probably 4 Naknown		
Record	v requir	Completed								autopsy findings available		
3ec	The law ate has t page 2 s	mpj						24a. Was a autops perforr	y prior t ned? death	o completion of cause of		
a			or the constant to madical				OC Plans of Pag	th (Check only on		es 2 No		
Vital		o Be	25. Was case referred to medical examiner?	Hospital:	2 ER/Outpatie	nt 3 DOA Othe	251		ence 6 Other (Sp	pecify)		
of	Phys er fhis eral di	Η.	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time o				ow injury occurred			
ion	Attending F r death. ector: After by the funer	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio		injury		Yes 2 □ No					
Division	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined			reet, factory, office		28f. Location (Si City or Town	reet and Number or n, State)	Rural Route Number,		
	ital or A ris after ral Dire		**************************************			He-	- Li 122			as stated		
	To the Hospital or Attenwithin 24 hours after deal within 24 hours after deal To the Euneral Director: completely filled in by the	Medical	29a. Certifier  (Check only 2 Medical Examone)	nysician: To the best of my miner: On the basis of exan and manyer stated.	knowledge, deal mination and/or in	th occurred at the time exestigation, in my of	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)		
	To the To the Complet	Med	29b. Signature and title of contifier	A and marker stated.		29c. License	number .	2	9d. Date signed (Mo	nth, Day, Year)		
	F X F S		+ Fee / / 1	ollin	~ ~	<i>か</i> >	2480	4	2/29	104		
•	di		30. Name and address of person who	completed cause of death	(Item 23a) (Type	, Print)	170	,	111	1		
	10		Robert Tre	o terson	md	Artur	C 1	Annap	chis N	10 21401		
		ate	31. Date filed (Maryth, Day, Year)	32. Registrar's S	ignature			U				
	Regist	rar	מושוג ה מ למחווו	TARRESS 1	U" ASIS							

State of Maryland / Department of Health and Mental Hygiene 2004 06638 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day .Month **Physician**  $\mathbf{Elved}$ February 29, 2004 2:35 PM John Lewis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Center Baltimore Rosedale Franklin guare If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 ☐ F 202 10 4150 90 Director June 18 1913 Slatington, PA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 le marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Exactinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Baltimore County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12 Parham Circle Apt. T-H 21237 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. tem 27 le marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Man Rossridge Apartments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thamas Lewis Grace Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Lewis (Wife) 12 Parham Circle Apt. T-H Baltimore, Maryland 21237 if of Heal Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If eny injury or Gardens of Faith Cem. Merch 3 2004 Baltimore Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Hone Inc 7401 Belair Road Baltimore, Maryland 21236 21. Signature of Funeral Service Licensee *s*nanacki 23a. Part1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Due to for as a consequence of): resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed physician and the burial-transit phelumonia Due to (or as a consequence of): Physician/Medical as IF FFMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. 1 ☐ Yes 2 ☐ No 9□ Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown as been si 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page certificate Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation within 24 hours after deatl To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide pellil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 037612 leb-29-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, MD 21237 Mohamad Alabrash MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 3 2004 Registrar

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1 4 2 3	e E		Decedent's Name (First, Middle, Last)		,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Dea	ath	2004 2004	3. Time of	Death J		
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	mine		4a. Facility Name (If not institution give s	street and number)		4b. City, Town,	or Location of De			ounty of Deeth	10.10			
Q Comments	\$ W	à.	Union Memorial H	4-			imore			N/				
Fune Direc			5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days			v, Year)	, Cou		ir Foreign		
10000			Usual Residence of Decedent		/			MUGUSI	31,14	62 VIV	Ginia			
arylan	1		10a. State 10b. County		y, Town or Lo						Od. Inside Ci	•		
he Mis		90   BC10	MD.	150	iltimo						1 XYes	2 🗆 NO		
with t	i	5	10e. Street and Number	to A.		10f. Zip Code	6.5		10g. Citize	n of What Cou	ntry?			
Jeath ms 23		runeral Director	825 Sona Da	12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of	Hispanic Origin?	(Specify Yes or No-		Race - Ameri	an Indian,			
6 after or Ite		ב	1 Never Married 2 Married	Amed Forces?		Yes, specify Cul	oan, Mexican, Pu	erto Rican, etc.)		Black, White,	etc.			
5-0036 72 hours after death with the Maryland natural, or Items 23e or 28e-f show	4	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		Yes 2 No	Specify:			pecify: BIG	ck			
21215-0036 dwithin 72 hours at giene.	1	Be Completed	15. Decedent's Educ (Specify only highest grade		(Give	ent's Usual Occu kind of work done OO NOT use retire	during most of w	vorking	-	of Business/In				
2121 d within giene. r than				Elementary/Secondary (0-12)	College (1-4or 5+)	C	lerk			Sen	ior Ce	inter		
be filed that dother					17. Father's Name (First, Middle, Last)	14			18. Mother's N	ame (First, Middle,	Maiden S	umame)		
arylan should be nd Mental	E E	0	Jefferson Davis	Long			Marg	unet Da	net Davis					
Maryland id 2 should be file th and Mental H)			19a. Informant's Name/Relationship (Ty)	n harden	19b. Mailin	- D.	t and Number or	Rural Route Numbe	r, City or T	Town, State, Zip	Code)			
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mor	5		1 Burial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify)	emoval from State	emetery, cren . Zióv	natory or other pla	1,1014	-1-04	DA	A STI	101			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23s or 28s-f show			21. Signature of Funeral Service License	le l	1	Name and Addr	ess of acility (		Do	ue lass	Flinde	German		
<b>0</b> 88 <b>5</b>	ouce		Carofon C. T	Dondan		1701	Mecul	The second of the second	Soulte		21217	1 00 110		
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that dused the death e cause in each line.	n. Do not ente	er the mode of dy	ing, such as cardi	ac or respiratory are	rest,		Approximate Interval Bety	ween		
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/Medi Examir	400		Tosulaing in ocality	Due to (or as a consequ	uence of):									
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1760, ate be executed by sician and by sicial property.			resulting in death) Last	Due to (or as a consequ	ience of):									
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Box 68 Jeath certifical	W/W		/We	IF F	IF FEMALE: 23c. If yes, outcome of pregnancy							23d. Date of delivery		
Box death cert established	- I	2	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnand Other (specify) _	у		230	Month		'ear		
P.O. I that the de	bye o	2	9 Unknown	9□ Unknown										
The law requires that the law requires signed by the late has been signed by the late	2	ה מ	Part II. Other significant conditions con Complications of Lupus		ulting in the un	derlying cause gi	ven in Part I.			contribute to th				
Cord  * require  been si	To to	. מנ	computations of hipus					. 1 Y	es 2 🗆 I	No 3 Prob	ably 4 D	nknown		
Records, he law requires t e has been signe	y (C	<u>.</u>						24a. Was a autops perfor	sv	24b. Were auto prior to cor death?	osy findings a npletion of ca	ivailable luse of		
Vital F sicien: Th			25. Was case referred to medical				00 Diagram of D	1 Yes	2 🗆 No	1 X Yes	2 🗆 No			
- × w		0	examiner?	ospital:	ER/Outpatient	3□ DOA Ot	han	eath <i>(Check only or</i> Home 5 - Resid		Other (Specifi	•)			
on of ding Phys. After this	T . C		27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe he			,			
SiO tendi death. tor: A	140	200	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No							
Division  or Attending after death.  Director: After the finds	ortification.		4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Si City or Town	treet and f n, State)	lumber or Rura	Route Numb	)e <i>r</i> ,		
Division of To the Hospitel or Attending Plant Within 24 hours after death. To the Funeral Director, After the Atmost			29a. Certifier 1 Certifying Phys	ician: To the best of my know	wledge, death	occurred at the ti	me, date and plac	ce, and due to the c	ause(s) ar	d manner as st	ated.			
he Ho n 24 h he Fu	adical	ב ב	(Check only 2 Medice! Examin one)	ician: To the best of my know er: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my	opinion, death occ	curred at the time, d	ate and pl	ace, and due to	the cause(s)			
To t To t	2		29b. Signature and title of certifier	17.		29c. Licen	se number	2	9d. Date s	igned (Month, i	Dey, Year)			
			Theodor M.	14TXmns			.C.M.E.		Febru	ary 24,	2004			
			30. Name and address of person who con				Shoon of 1	Dolb.		7 7 7	1001			
1	State		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure		screet,	Baltimore	, Mar	yland 2	1201			
Reg	jistrar	100	MAR 0 3 2004	Garage &	8,00	els								

State of Maryland / Department of Health and Mental Hygieney 06640 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month February 27, 2004 F. Lavezza, Sr. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Perry Hall

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Pebruary 28, 1931 8567 Castlemill Circle Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) Mary land **Funeral** 1 M 2 □ F 215-24-8514 72 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, Ita Medical Exercitive most be notified at once. 10d. Inside City Limits Baltimore MD Perry Hall 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8567 Castlemill Circle 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XXY &s 2 □ No KOrea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Concrete construction Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo Anthony Lavezza Mary Lazzaro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois J. Lavezza-wife 8567 Castlemill Circle, Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/2/04 Baltimore, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Consee William G. Dau 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Rd., Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Comies a netastute 18 monte /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. by Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 1 HO Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 20 No Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the l within 2 29c. License number 29d. Date signed (Month, Oay, Year) 29b. Signature and title of certifier D 15808 LUTUGZ-164 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kandell de 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 3 2004 Registrar

	1 - For State Registrar		of Maryland / [	Certificate of	f Death		Reg. No.	U 4	06641	
ian	Decedent's Name (First, Middle     Joyce Ar		V			2. Date of De Month March	Dav	Year 2004	3. Time of Death 6:15 P M	
ical ner	4e. Fecility Name (If not institution		/	4b. City, Town,	, or Location of Dea		-	y of Deeth	0.13 P	
nei	8653 Tower Driv	ve		Laure			·	Howard		
	5. Social Security Number 215–40–6077	6. Sex 1 □ M 2½√2 F	7. Age (In yrs. last bir 60				y, Year)		lace (State or Foreign htry) 71and	
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City L									
jo		ward		aurel					1 ☐ Yes ZONo	
ireci	10e. Street and Number	, and a			10f. Zip Code 10g. Citizen of What Country?					
Funeral Director	8653 Tower Driv	ve		2	20713		United	1 Stat	es	
uner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		J.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto			- 14. Ra Bia	ce - Americ ick, White,		
þ	1 ☐ Never Married 2反 Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, G	Ve	1 ☐ Yes 2 🛣 N	o Specify:		Speci	Specify: White		
etec	15. Deceden (Specify only higher	t's Education st grade completed)	16a.	Decedent's Usual Occ (Give kind of work don	e during most of w	orking	16b. Kind of E	Business/In	dustry	
Completed	Elementary/Secondary (0-12) College (1-4or 5+)			`life. DO NOT use reti anager / Ow	,		Eastern Homes			
Be C	17. Father's Name (First, Middle,	Last)		<u> </u>	1	ame (First, Middle,				
ToE	James Knisley		Ever Ho	obbs						
	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
	Gilbert A. Mobley, Sr Spouse 8291 Washington Blvd. Jessup, Maryland 20794  20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - City or Town, State									
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State									
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Gary L. Kaufman Funeral Home At MMP., Inc.									
1	> Moc. Ha	ademan		Gary L. K 7250 Wash	auiman Fi ington Bl	neral Ho lvd. Elk	me At M ridge.	MP., Marvl	Inc. and 21075	
	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	each line.	not enter the mode of d	ying, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between	
	Immediate Cause (Final disease or condition	a. /	DENO.	CARCIT	YOMA	OF L	LUNG	E	Onset and Death	
	Due to (or as a consequence of):  WITH METASTASIS TO THE LIVER  OVER									
ē	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequence		73/3 /	0 11/2	ZIVE	-/	Two.	
xaminer	cause. Enter Underlying Cause (Disease or injury that injuried eyents								YEARS	
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licai		d								
2	IF FEMALE:	23c. If ves. ou	tcome of pregnancy	The Three allows allow as closed the party			224 D	ato of dollar	n.	
/Me	23b. Was decedent pregnant	1□Live	birth 2 Fetal death	3 ☐Ectopic pregnar 5 ☐ Other (specify)	псу		23d. Date of delivery  Month Day Year			
cian/Me	in the past 12 menths?		OWD							
hysician/Me	in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr	OWIT							
ed by Physician/Medi	1 □ Yes 2 🗖 No	_		n the underlying cause (	given in Part I.	23e. Did to		tribute to th	e cause of death? ably 4 Unknown	
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ompieted by	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	_		n the underlying cause (	given in Part I.	24a. Was	Yes 2□No an 24b.	3 Prob Were auto prior to cor death?	ably 4 □Unknown	
e Completed by	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ons contributing to o			26. Place of Do	24a. Was autop perfo	res 2 No an 24b. osy rmed? 2 No	3 Prob Were auto prior to cor death?	ably 4 Unknown	
To Be Completed by	Part II. Other significant condition  25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	leath but not resulting in	tpatient 3□ DOA	26. Place of Di	24a. Was autor performent of the control of the con	an 24b. Dsy rmed? 2 No	3 Prob Were auto prior to cor death? 1 Yes	ably 4 Unknown  psy findings available  inclination of cause of  2 No	
o Be Completed by	9 Unknown  Part II. Other significant condition  25. Was case referred to medical examiner?	Hospital: 1 28a. Date (Mor	leath but not resulting in	tpatient 3□ DOA C Time of 28c. In njury	26. Place of Di	24a. Was autop perfo	an 24b. Dsy rmed? 2 No	3 Prob Were auto prior to cor death? 1 Yes	ably 4 Unknown  psy findings available  inclination of cause of  2 No	

To the Hospital within 24 hours a To the Funerel C completely filled

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)
MAR 0 3 2004

30. Name and address of ABDUL N

who completed cause of Fath (Item 23a) (Type, Print)
EEM, MD 3450-FORT MEADE ROAD, SUITE LOO, LAUREL, MD

29c. License number
D\_ 21294

29d. Date signed (Month, Day, Year) 03-02-2004

State of Maryland / Department of Health and Mental Hygiene 2004 06642 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 1920 DM 2004 Η. Madden Sr. Never /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Buttung Hunder 1 Year If Under 24 Hrs.
Months Days Hours Addition Health Care Agnes Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X** M 2□ F 219-34-2699 13 MD Director 63 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or than "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 XYes 2 No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A.

14. Race - American Indian,
Black, White, etc. 1239 North Augusta Ava 21229 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. and It iden 27 is marked other than "natural", or lite any or other traumalic event, its Medical Examinary or other traumalic event, its Medical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Johnson & Johnson Elementary/Secondary (0-12) College (1-4or 5+) Trucking Firm Tractor Trailer Driver llth grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mable Parrott ၉ John M. Madden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21229 1239 North Augusta Ave, Baltimore Md Ann S. Madden-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pag Department Importent: f any injury o 3/6/04 \*4 □ Donation 5 □ Other (Specify) Loudon Park Baltimore, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility F/H West March 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore Md Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** lung 2 months Cancer Metastatic resulting in death) /Medical Due to (or as a consequence of): Examiner lung disease Mears Chromic Obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 1 No 1 ☐ Yes Division of Vital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 2 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: : After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 1, 2004 D 585 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21229 Lynn 900 Caston Avenue MID. Tao 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 03 Jacker 2004

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month March **Physician** Joseph Anthony Mai Sr. 2004 8:46 p M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3775 Dug Hill Drive Manchester Carroll 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign New Jersey 5. Social Security Number **Funeral** Days 146-22-8266 74 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State or itams 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Maryland Carroll Manchester Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3775 Dug Hill Drive 21102 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1-∑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or item eny injury or other traumatic event, the Medical Exempted 2008. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No If Yes, Give 18-1954 Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Food Sales Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick Mai Dora Forman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jean Mai - wife 3775 Dug Hill Drive, Manchester, Md. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 24 Cremation 3 Removal from State Metro Crematory March 6,2004 Baltimore. Md. ⁴ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Eckhardt Funeral Chapel P.A.
329 Charmil Dr. Manchaston Echlado Charmil Dr. Manchester, Md. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IMMED Physician MULTIPLE /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, priscuss or injury Due to (or as a consequence of) Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARCINOMA 1 Yes 2 No 3 Probably 4 Munknown 05 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed URINOM 1 Yes 2 No 1 Yes LOWER GUADRANT 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 🔁Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO 1663 3/2/04 30. Name and address of person who completed cause of death (from 23a) (Type, Print) 906C WACHINGTON 10000 WESTMIN STEE MD 21157 INCENT 31. Date filed (Month, Day, Year) 32. Registrar's Signatore State MAR 0 3 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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- No. 180 pt	· .	Registrar  1. Decedent's Name (First, Middle, Last)						2. Date of De	ath		3. Time of Dea	ath	
Physicia		EDWIN J.	MOSM	11LLER	JR.			Febru	Day arv 2	9, 200	4 2150 I	РМ	
/Medic Examine		4a. Facility Name (If not institution, give stree			4b. City, Town, or	Location of	Death		4c. C	ounty of Dea	th		
LAGITIII	ÇI K	Latitude 3905.151N Longit		r I	Sandy	y Poin	t		An	ne Arı	ındel		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24		8. Date of Bir (Month, Da	th ay, Year)	9. Bii	thplace (State or Fo	oreign	
Director		213-50-7570 <sup>1</sup> 3 <sup>t</sup>	<sup>2□ F</sup> 52	Yrs.	World S Days	1100.10		Dec.03			yland		
D ≥		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Loca	ation						10d. Inside City L	imits	
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Ne M	Director	Md. Anne Arund	el co.	Pasade	10f. Zip Code				10a. Citize	en of What C	ountry?		
with a or	Ö	208 Inlet Drive			211	22		-			S.A.		
leath	Funerai	11 Marital Status 12.1	Was Decedent Ever in U.S.	13. W	as Decedent of Hi Yes, specify Cuba	ispanic Origi	n? (Spe	cify Yes or No	)- 14		erican Indian,		
r Iter	Ē		Armed Forces? □ Yes 2 7 No f Yes, Give A				Puerto F	Rican, etc.)	1	Black, Whi			
al', o	by	3 Widowed 4 Divorced	f Yes, Give 44 Year or Dates:	1 11	☐Yes 2∭ No	Specify:			3	Specify:	white		
72 hc	Completed	15. Decedent's Education (Specify only highest grade control of the control of th		(Give ki	nt's Usual Occupa	during most o	of workin	ng	16b. Kind	d of Business	/Industry		
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lygier her ti	To Be Cor	12	+2	OW	ner	18 aMother'	s Name	Wiret Middle	Serv Maiden S	ice I	nc.		
be fi		17. Father's Name (First, Middle, Last) Edwin J.	Mosmi1	ler. S	Sr.	Anne		Szamsk I	1	Szar	ncki		
d Men mark maric		19a. Informant's Name/Relationship (Type,			Address (Street a			l Route Numb	er. City or				
d2s than t7 is		Robin L. Mosmiller			nlet Dri								
Heal Heal tam S		20a. Method of Disposition	20b. Plac	ce of Disposi	tion (Name of story or other place			ate 1			Town, State		
ages ent of it: If i		1 ☐ Burial 2▼ Cremation 3 ☐ Remo 1 ☐ Donation 5 ☐ Other (Specify)	oval from State Ba		Cremator		3/04	/2004	Ba1	.timore	e. Md.		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exertities trained be rollified at once.		21. Signature of Funeral Service Licensee		22.	Name and Addres	ss of Facility	1.00	1997:					
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Attanding r death. sctor: After by the fune	fica	3 Suicide 6 Could not be	8e. Place of Injury - At hom	ne, farm, stre	et, factory, office		12	28f. Location	(Street and	Number or I	Rural Route Number	20.11	
i e e	Certification:	4 Homicide	building, etc. (Specify)	~			8	hells	wn State	Say	Manship	AR	
ospite hours unera y fille			an: To the best of my know										
To the Hospitel of within 24 hours af To the Funeral D completely filled in	Medical	one)	On the basis of examination and manner stated.	on and/or inve			OCCUIT	ou at the thine					
With To 1	2	29b. Signuture and title of certification	2000		29c. Licens					signed ( <i>Moi</i> h 01,	th, Day, Year) —— 2004		
5		Totalle	Tollel	~	11-23-22	11.10.							
3		30. Name and address of person who comp	leted cause of death (Item	1	orint) 1 Penn S	Stroot	D-	1+i	o Ma	nul and	L 21201		
Sta	ato	31. ate filed (Month, Day, Year)	32. Registrar's Signatu		crift 5	occeet	, Ba	TUNE	e, Ma	тАтапу	. 414VI		
- U10	-11		1										

State Registrar

ORIGINAL

		1 - State Registrar		aryland / Dep <i>Ce</i>		ite of i			Reg. No	2004		
Physic	ian	1. Decedent's Name (First, Middle, Las	t)					2. Date of De Month	ath Da	y Year	3. Time of	
/Medi		Melvin L. Mathe						FEB		2004		A
Exami	ner	4a. Fecility Name (If not institution, give				-	Location of Dea	th		County of Dea		
	- 1		tealthco		-		LOQ C			LARYL		
Funeral Director		5. Social Security Northber 6. S 216-16-2646  Usual Residence of Decedent	7. Ag XIM 2□F	e (In yrs. last birthday 79 Yrs.	Month	der 1 Year s Days	Hours Min		th ly, Yeer) , 19	24 Mar	thplece (Stete or ountry) yland	r Forei
whom 72 nouts arter death with the Maryland ene. then "natural", or items 23a or 28a-f ehow he Medical Examiner mant be notified at		10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside Cit	ty Limi
2	jo	Virginia Hanove	•	Ashla	and						1 ☐ Yes	2 🗓 1
ital Hygiene. d other then "natural", or items 23a or 28a-f ehow event, the Medical Examiner must be notified at	Director	10e. Street and Number				Zip Code			10g. Cit	tizen of What Co	ountry?	
38.0	Ö	9122 Stumpy Road	1			2300	5			U.S.A.		
as 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13	Was Dec			Specify Yes or No to Rican, etc.)		14. Race - Ame		
- 8	Fur	1 ☐ Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ ! If Yes, Give	NO TATE OF				to Rican, etc.)		Black, Whit	e, etc.	
E B	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	MM II	1 ∐ Yes	2 <b>X</b> No	Specify:			Specify: Wh	ite	
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Hygiene. other then	on	12		Pr	inte	r			Pr	inting		
other vent,	Be	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	, Maider	Sumame)		
ind Mental marked o	To	Joseph J. Mather					Grace	L. Cal	trid	er		
th and Men 7 is marke traumatic	-	19a. Informant's Name/Relationship (	ype, Print)	19b. Mai	ing Addre	ss (Street a	and Number or R	ural Route Numb	er, City	or Town, State,	Zip Code)	
= 0 -		Florence Mather	(Wife)	9122	Stu	mpy R	oad Ash	land, V	irgi	nia 230	005	
of Heal fitem 2 r other		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (A	ame of	9)	Date		ocation - City or	Town, Stete	
nent of l		1 ☑ Burial 2 ☐ Cremation 3 ☐  1 ☑ Donation 5 ☐ Other (Specification)		Quantico			1	h 2 200	i n	uantico	Virgir	n i .
	1	21. Signature of Funeral Service Licen		qualitation	2. Name	and Addres	s of Facility	11 2,200	+ Q	uantico	VILETI	.11.
Departr importa eny inju		Vie man and	Telan	welled W	itzk	e Fun	eral Hon	ne of Cat	ons	ville,	Inc.	
70		23a. Part1. Enter the disease, or com	trications that caused	the death. Do not er	ter the m	ode of dvin	Such as cardia	c or respiratory a	onsv:	ille, M	Approximate	
		shock, or heart failure. List only	one cause on each lin	10.							Interval Betw Onset and D	Ne en
nysician		Immediate Cause (Final disease or condition resulting in death)		SHOCK-	HU	DIL	LGAN	FAILUS	26		teb 2	3/2
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		Sequentially list conditions,	0.	a consequence of):	SHO	XX	- Hau	E HYOUA	KOM	L IMI	Feb 23	<b>5</b>  2
sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as	a consequence on.							(eb23	10
and I-tran	хап	that initiated events resulting in death) Last	c. Pue to (or as	a consequence of):							(000	7
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te has been signed by the attending physician and reage 2 should be detached for use as the burial-transit	Completed							24a. Was			topsy findings a	
page 2	EO							perto	rmed?	death?	2□ No	1030
this certificate ral director, pag	BeC	25. Was case referred to medical					26. Place of De	ath (Check only o		1	20.10	
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or death. ector: After by the funer	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Da	Y Yeer) Injury	М	Work	r res 2 □ No					
death.	flea	3 Suicide 6 Could not be	28e. Place of Inju	ury - At home, farm, s	reet, fact	ory, office		28f. Location (	Street an	nd Number or Ru	ıral Route Numb	ber,
after death Director: J In by the f	Certification:	4 Homicide	building, et	c. (Specify)				City or Tox	vn, State	))		
within 24 hours after de To the Funeral Directo completely filled in by th	edical C			of my knowledge, dea examination and/or i								
the mpla	Mec		and manner sta	1180.	2	9c. License	number		20d Dat	te signed (Monti	h Day Year)	
To		29b. Signature and title of certifier	k 1			-			ESU. Da	O /	0 00/	
X		rovul	1	- 17		1-1-	7603	1	-EB	16	1200	7
41		30. Name and address of person who		eath (Item 23a) (Type	, Print)							
		PETEL DONME?	St. Agr	nes Hospit	al 90	0 Cat	on Ave	Baltimor	e, M	D 21229		
		31. Date filed (Month, Day, Year)	20 Deciete	ar's Signature								

DHMH 17 Rev 1/2001

MATHER, MELVIN

State of Maryland / Department of Health and Mental Hygiene 2004 State
Registrar AMEND ITEM #5 PER FH G829 3/19/04 J@ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Monthy ARCPay Year 1214 **Physician** 2. 4:00 Leonard L. Marzullo 1 /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4a. Facility Name (It not institution, give street and number) Examiner Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5**21**63ia+8e**2**8ity+8407 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** <del>213-28-2407</del> May 15, 1924 Director Italy Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examinar must be rediffed at 1 √Yes 2 No Maryland N/A Director Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 6541 Hilltop Avenue 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give XX Year or Dates: 1 ☐ Never Married 2 X Married 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Bethlehem Steel 12 permit Pages 1 and 2 should be filed.
Department of Health and Mental Hygis Important: If tem 27 is marked any injury or other to once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Michele Marzullo Anna Caruso ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmela G. Marzullo/Wife 6541 Hilltop Avenue Baltimore Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \*4 □ Donation 5 Ø Other (Specify) Entombment Parkwood Cemetery 3-6-04 Baltimore Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine so the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the al 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 🗌 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? ALZHEIMER DEMENTIA 24a, Was an cate has I page 2 s autonsy rmed? 2 No perform certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Impatient 은 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Injury at Work? After 5 Pending investigation М 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dira Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37254 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON P. LIM. M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

	,		For State Registrar	State of Maryland	l / Department <i>Certificate</i>	t of Health and Ne of Death	Mental Hygie		06647
			1. Decedent's Name (First, Middle, Las.	1)			2. Date of Death Month	Day Year	3. Time of Death
	Physicia		Gloria			Powell	Februry	Day Year	0939 AM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, 1	Town, or Location of Death		4c. County of Death	
			The Johns Hookins t	tosatal		timore			1/A
	Funeral		5. Social Security Number 6. Se		- Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Dey, Ye	9. Birth	place (State or Foreign intry)
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	D	}	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location		,		10d. Inside City Limits
	sho	ā			6	BALTIMO	05 1.5	-11	1 XYes 2 □ No
	or 28e-f show	ect	10e. Street and Number	IMORE	10f, Zip			. Cifizen of What Cou	intry?
3	NIL S	ä	15055 W) CC	mail David April	E#B	2120	a i	115	_
	eath	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	5. 13. Was Deced	lent of Hispanic Origin? (S ify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Amer	ican Indian,
	ritan	표	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 2 No			o Rican, etc.)	Black, White	, etc.
Š	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2	No Specify:		Specify: BL	ACK
	filed within 72 hours after death with the Maryland Hygiene. Hydiene. Then 1990 or 28e-f show ther then "natural", or items 23e or 28e-f show ant, the Mydical Exam or must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Usua (Give kind of wor	k done during most of wor	king 16	b. Kind of Business/li	ndustry
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	ild be filed with lental Hygiene. ked other that ic event, the h	Be	17. Father's Name (First, Middle, Last)	0		18. Mother's Nan	ne (First, Middle, Mai	iden Sumame)	(m)
	should be nd Menta marked umatic ev	은	LARA LE	E DAVI	T	ELA	NE	JOHN	SON
	E a		19a. Informant's Name/Relationship (7	/	19b. Mailing Address	(Street and Number or Ru	1		1
ນົ	1 and Health Im 27 Ther tr		20a. Method of Disposition	L (DAUGHTER)	ace of Disposition (Nam	1.6/11		c. Location - City or T	V. MO 31009 own, State
2	if it or o		1 Bunal 2 □ Cremation 3 □	Removal from State	metery, crematory or or	ther place)			1
Dalitimo	permit. Pages 1 ar Department of Hea Important: if item any injury or othe once.		<ul> <li>4 □Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licen</li> </ul>	11 40.	NG MEMORIA	d Address of Facilities		UOOD LAA	
0	Depa Impo any i		Vi Late	Vis Minin	7 3055	PH H. BRO	AVE A	FUNERAL ALTIMORE,	WA 21217
*	*664		23a. Part1. Enter the disease, or comp	olications that caused the death	. Do not enter the mod	e of dying, such as cardiac			Approximate
	Newstates		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.					Interval Between Onset and Death
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	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· Acute Per	rel Failur	٠			three walks
Ď	a exe		resulting in death) Last	Due to (or as a consequ	ence of):				
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X D	ath o	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic pr			23d. Date of delin	very Day Year
j.	the de	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	atti 3 Ottier (sp	ocny)			
7	that ted by	Ph	Part II. Dther significant conditions c	ontributing to death but not resu	Iting in the underlying c	ause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
SD	law requires that the as been signed by th 2 should be detache	d by	Methicillin Resist	ent Stap Wooder	Auren b	actorenia	1 🗀 Yes	2 ☐ No 3 ☐ Pro	bably 4 Unknown
cord	w requir been si should l	Completed		•			24a. Was an	24b. Were aut	opsy findings available
Ď Y	The lavate has	E C					autopsy performe	d? death?	ompletion of cause of
	ician: The lav certificate has rector, page 2	O	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2 ≥ ath (Check only one)	No 1 Yes	2,5,10
	Physician: r this certific ral director,	O B	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2 1	ER/Outpatient 3 DC	Other: 4 Nursing H	lome 5 Residence	e 6 Other (Spec	ify)
101	ig Ph ter th neral	n: T	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 2	8c. Injury at Work?	28d. Describe how	injury occurred	
0	endir sath. or: Af he ful	atlc	2 Accident investigation		М	1 Yes 2 No			
Division	r Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory	, office	28f. Location (Stree City or Town, S	et and Number or Ru. State)	ral Route Number,
	urs af rral D								
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical		ysician: To the best of my knowniner: On the basis of examinat and manner stated.					
	o the o the omple	Med	29b. Signature and title of certifier	4 -		c. License number		. Date signed (Month	
)	<b>⊢</b> s ⊢ 0	1	> James The	MIND	ļ	RES-000	Fe	brugg 2	8,2004
	, \.		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)				
	Ч		Junes O. Mudd,	Johns Hopkins Hors	sital, 600 U	RES-000	tract, But	Hoore, May	and 21287
(87)	Sta	ate	31. Date filed (Month, Day, Year)	Trogistial solgital	ture Bracks				

State of Maryland / Department of Health and Mental Hygiene 200 L06648 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Paul Rowan Paxton February 25, 2004 7:18 P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1**X** M 2□ F 79 Yrs. Pennsylvania March 11, 1924 195-14-3806 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6825 Campfield Road Apt. 8E 21207 14. Řace - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

12. Was Decedent Ever in U.S. Armed Forces?

12. Was Decedent Ever in U.S. Armed Forces?

13. Was Decedent Ever in U.S. Armed Forces?

14. Was Decedent Ever in U.S. Armed Forces?

15. Was Decedent Ever in U.S. Armed Forces?

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17. Was Decedent Ever in U.S. Armed Forces?

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19. Armed Forces.

19 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Specify: þ 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Realtor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, <u>Lillian N.</u> Nuttle Μ. Paxton Marion 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is m any injury or other treum once. 6825 Campfield Road Apt 8E, Baltimore, Marylan
Date 20c. Location - City or Town, State <u>Mary Jane Paxton</u> Wife Maryland altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State
4 Donation 5 Other (Specify)
21. Signature of Finer's Service: Licensee Hilltop Service Corp. | 2-27-2004 Towson, Maryland permit. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 lay 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** weeks recurrent /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records. obstructive Lung disense 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Stroke 1 ☐ Yes 2 No 1 ☐ Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death the 6 Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) · (m) who completed cause of Fatty (Item 23a) (Type, Print) N. Charles St. Balto Md 2120x 63mc 6701 32 Registrar's Signature 31. Date filed (Month State Registrar

:PM 14-01351 Tames Pendergast

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrer	State of Maryla	C C	ertificate of	Death		Heg. No.	200	14 06649
	Physicia	an	Decedent's Name (First, Middle, I     James	Penderga	o.t			2. Date of De Month	Day	Yea	3. Time of Death
	/Medic	al				4h City Town o	Location of Death	Februai		200 County of De	
	Examin	er	4a. Facility Name (If not institution, o University of Mai	ryland-Shock T	rauma		timore			altimo	
	Funeral Director		5. Social Security Number 222-52-8527	. Sex 7. Age (In yr	s. last birtho	(ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De Octobe)	th by, Year) c 6, ]	9. B 1963 1	Sinthplece (State or Foreign Country) MILFord, DE
ī	pu »		Usuel Residence of Decedent  10a. State 10b. County	100	City, Town o	r Location					10d. Inside City Limits
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or hams 23s or 28s-f show aumatic event, the Marylaal Examine quast be notified at	tor	Maryland Kent Co		olts						1 ☐ Yes 2 <b>X</b> No
	th the	Director	10e. Street and Number			10f. Zip Code				zen of What	Country?
	ath wi		33838 Golts Ros	ad		21635			USA		
	iner de	Funeral	11. Marital Status  1 Never Married 2 Narried	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 2 2 No	U.S.	13. Was Decedent of H If Yes, specify Cuba		ecify Yes or No Rican, etc.)		Black, Wh	merican Indian, hite, etc.
	Frei', or	l by l	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔼 No	Specify:			Specify:	White
5	72 hc natur	letec	15. Decedent's (Specify only highest		16a. D	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired	ation during most of work	ing	16b. Ki	nd of Busines	ss/Industry
7	within ene. then	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		Salesman	,,			Furi	niture
2	Hygi other	Be Co	17. Father's Name (First, Middle, La				18. Mother's Nam	e (First, Middle	, Maiden	Sumame)	
ā	Venta Venta Irked Itc ev	To B	John W. Penderg	ast			Barbara	(Munce	≥)		-
	2 sho		19a. Informant's Name/Relationship			lailing Address (Street					, Zip Code)
ב ת	1 and Health em 27 ther t		Barbara Carter/I		. Place of D	370 Golts R isposition (Name of		Maryla Date	and 20c. Lo	21635 cation - City	or Town, State
5	Pages nent of int: If It iry or o		1 Burial 2 XCremation 3 4 Donation 5 Other (Spe			crematory or other place sin Cremato		604			, Delaware
Daitimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene important: if Item 27 le marked other then "naturel", or items 23e or 28e-1 show any inly or other traumatic event, the Marylan Examinar quist be notified at any inly or other traumatic event, the Marylan Examinar quist be notified at any inc.		21. Signeto 6 of Funda application	the to	1113	22. Name and Addre	ss of Facility hertv Fu Delaware	ıneral l Ave, Wi	Home 11in	gton I	De 19806
Ç2.	100		23a. Part I. Enter the disease, or co shock, or heart failure. List or			enter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a CONTRO	rgu	shot wou					Onset and Death
	/Medical Examiner			Due to (or as a cons	equeñce of)	:					
	7	ner	Sequentially fish conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence of)						
	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of)				_		
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200	tificate ig phy as the	ledical		0.							
C. BOX	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pred 1 □ Live birth 2 □ Fr 4 □ Pregnant at time of 9 □ Unknown	etal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	/		2	23d. Date of 6 Month	delivery Day Year
7	s that t ned by a detac	by Ph	Part II. Other significent condition	s contributing to death but not	resulting in th	ne underlying cause giv	en in Part I.	23e. Did t	obacco u	se contribute	to the cause of death?
SDJ	requires een sign rould be							1 🗆	Yes 2	□ No 3□	Probably 4 Unknown
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0	> 00	10	1XXYes 2 No 27. Manner of Death	Hospital: 1 Xinpatient 2 28a. Date of Injury	ER/Outp	atient 3 DOA Oth	4   Nuising He	ome 5 Resi			pecify)
	ding th. After funer	tlon	1 Natural 5 Pending 2 Accident investiga	(Month, Day Year	) Inju	ıry Wor	Yes 2 □No	Susjet		HOTOL	RE
DIVISION	Attender deal	ertification:	3 Suicide 6 Could no determin	t be 280 Bloom of Injury A	t home, farm				Street an	d Number or	Rural Route Number,
בֿ	rs after all Dir	Cert	4 Tromboo	AT Wo	**		Ü				lors M)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medicel E	Physician: To the best of my li xeminer: On the basis of exame and manner stated.	knowledge, o ination and/o	death occurred at the til or investigation, in my o	me, date and place, pinion, death occur	and due to the red at the time,	cause(s) date and	and manner place, and d	as stated. ue to the cause(s)
	To th Within To th compl	Me	29b. Signature and title of certifier	111		29c, Licens	se number		29d. Dat	e signed (Mo	onth, Dey, Year)
•	/		Millione	melshoull is	W		O.C.M.E.		Febr	uary 2	2, 2004
	6		30. Name and address of person w	ho completed cause of death (I	tem 23a) (Ty 1	ype, Print) 11 <b>Penn St</b>	reet, Bal	timore,	Mar	yland	21201
	Sta Registi		31. Date filed (Month, Day, Year)  MAR 0 3 2004	32. Registrar's Si	gnature	pake					

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month MARY ANNA POLK 02 つう 04 /Medical 11pm 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death Examiner 4c. County of Death BLAKEHURST TOWSON BALTIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min 1□ M 2□ F 217-36-2835 Director 88 1915 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location ral', or items 23e or 28e-f show Examiner must be notified at 10d. Inside City Limits MD. BALTIMORE Director TOWSON 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other then "netural", or items 23e or : ury or other treumatic event, the Medical Exeminer must be In 1055 WEST JOPPA ROAD 21204 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Martin Luther Sutch Minnie Elton Deitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Polk/Son 2101 Harbor Drive Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of H Important: If Ite eny injury or ot once. 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/26/04 Baltimore, MD Druid Ridge Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Week Examiner Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lineage or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 🗆 Yes 2 0 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. neral Director: A filled in by the f 1 □ Yes 2 □ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a
To the Funeral C 1 certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) MMY MD CANRUES

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Mich )4-1 AKG	ael Pom 485	ipe <u>i</u>	y Please Unpend Item #23a For Amend Item 19b 1-Registrar	Type or Print 27 per more pestate of M	1t in Elja 1703/04	Departm	ble Ink. Ens tas ent of Health ate of Deati	and Me	ental Hygi	Are Legible. ene 200	
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	Physici /Medi		Michael	ton	2 pey	<b>\</b>			February	$y^{Day} = 27, 200$	4 8:25 PM
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707	Funeral Director	**		Gex 7. Ag	e (In yrs. last 40			er 24 Hrs. Min.	B. Date of Birth (Month, Day )	Year) 9. Bi	Thplace (State or Foreign ountry)
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980	after dea or Items	by Funerail	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Pres 2 If If Yes, Give Year or Dates:			ecedent of Hispanic Copecify Cuban, Mexicos 2 No Specif		rfy Yes or No- can, etc.)	14. Race - Am Black, Whi	
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Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Special Signature of Funeral Service Lice	5)	200. Place ceme	of Disposition ( etery, crematory)	or other place)	3/6	104 7	oc. Location · City or andalls 1	Town, State
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	To the within To the comple	Me	29b. Signature and title of certifier	a. /		1	29c. License number			. Date signed (Mont	
			30. Name and address of person who		eath (Item 23a	a) (Type, Print)				ebruary 28	
	Sta		31. Date filed (Month, Day, Year)		ır's Signature		1 Penn St	reet,	Baltimo	re, Maryla	ana zizui
	Registr	ar	MAR 0 3 2004	h. Mys 1-8-	10	poor	Kal .				

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		Funeral Director			1 M 2 □ F	9:		Months D		Hours	Min.	8. Date of Bir Month, Da	ľ9 <b>',</b> ľ	912	Countr	Ce (State or V) UK	CRAINE
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ya P	36	or ite	by Funeral Director	3601 FORDS LANE  11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:			Was Deceden If Yes, specify				cify Yes or No Rican, etc.)		14. Race	- American c, White, et		
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35	Baltimore,	Pages 1. nent of He ant: If itan		20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 0 14 □ Donation 5 □ Other (Spec			Place of Dispo cemetery, cren R SINA	natory or othe	r place)		3/2/	<sup>ate</sup> 2004			City or Tow	n, State S, MD	)
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 06653 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 3:30 A. 2004 CHRISTOPHER GEORGE PERENTESIS March /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson
1 Year II Under 24 Hrs. HCR Manor Care - Dulaney 8. Date of Birth (Month, Day, Year) May 2, 1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F Yrs. 217-03-0281 Director 87 Canada Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r items 23a or 28a-f show ther must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code unit 402 21204 U.S.A. 31 Lambourne Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No II Yes, Give Year or Dates: ₩₩∏∏ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 X Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White natural er than "nature, Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Proprietor Restaurant years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Helen Perentesis Konstant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a (wife) 31 Lambourne Road unit 402 Towson, Maryland 21204 Anne K. Perentesis 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of t 1 ☐ Burial 2 MCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 3-2-04 Green Mount Crematory Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatore of Funeral Service Licensee Pitchell-Wiedefeld Funeral Home, 6500 York koad Baltimore, Mary ld Funeral Home, Inc. Baltımore, Maryland 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

DN. Dum m. Ca Approximate Interval Between Onset and Death 1eumonia Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 PNo 3 ☐ Probably 4 Dunknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed/ 2 No certificate 1 ☐ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar (HOZMO4

31. Date liled (Month, Day, Year)

**ORIGINAL** 

0

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2004 06654 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Wilbur Roese February 2153P M 29,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5221 Trumps Mill Road Baltimore County Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1□ M 2□ F 216 12 0506 80 Director June 2 1923 Baltimore, Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other then "natural", or Items 23a or 28a-f shov other traumatic event, it a Medical Example must be notified at 1 ☐ Yes 2 ☐ No X Maryland Baltimore Baltimore County Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5221 Trumps Mill Road 21206 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XIYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Marned Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) NA Elementary/Secondary (0-12) and Mental Hygiene. Factory Worker Valcan Hart 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be ind Mental Wilbur Valant Elizabeth Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is nony injury or other traum Dr. Wilbur Roese, M.D. 4701 Fullerton Avenue Baltimore, Maryland 21236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Cemetery March 3 2004 Howard Co, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility assam Funeral Home Inc 1880ho ( 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition a. Hyportensino Arterio solonotio Cardiovascular Disesse **Physician** 10 years resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in dealh) Last Due to (or as a consequence of) transit certificate be executed and Due to (or as a consequence of): attending physicien a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. | ☐Yes 2☐No 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No of Vital 1 ☐ Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c funeral dire 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 94 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hill CT. Luther ville, Maryland 21093 MD PHILIP MILITELLO 6 Trimble 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 3 2004

	1	For State Registrar	Stat	e of M	larylan	id / Depa <i>Cer</i>	irtment of l tificate of	Health Deat	and N h	Mental H	ygier Reg. I		004	06655
Physiciar /Medica	1	Decedent's Name (First, Middle,								2. Date of D Month March		2004	Year	3. Time of Death 8:20AM <sup>M</sup>
Examine	-	a. Facility Name (If not institution, Wesley House	give street an				4b. City, Town, Baltim	ore				4c. County N/A		
Funeral Director	2	212-05-1528	6. Sex 1 □ M 2√2 X		ge (In yrs. 96	last birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. s Min.	8. Dete of E (Month, I 0ct. 1	,19	07	Coun	lace (State or Foreign ity) / I and
Maryland		Jsual Residence of Decedent 10a. State 10b. County  MD N/A				ty, Town or Lo							10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
th with the Mar 23a or 28e-f si	מו חוובר	10e. Street and Number 7109 Park Driv	re				10f. Zip Code 212					Citizen of V	Α.	
36 rs after dea r, or items	Dy ruilerai	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	Arme	Decedented Forces Yes 2 (Xes, Give	No	l l	Was Decedent of fYes, specify Cul I□Yes 21 No	ban, Mexic	can, Puerto	pecify Yes or No Rican, etc.)	10-		e - Americ ck, White, e	etc.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23a or 28e-f show eny injury or other treumetic event, the Medical Examination withing at once.	Dataiduloo	15. Decedent' (Specify only highes Elementary/Secondary (0-12)	s Education grade comple			(Give life. l	dent's Usual Occu kind of work done DO NOT use retin	during m	ost of work	king		. Kind of Bi	usiness/Ind	dustry
and 21 d be filed wighter the content, the	מ	10 17. Father's Name <i>(First, Middle, L</i> Thomas R. Wann				Sup	pervisor			ne (First, Midd	le, Maio	en Sumam		Company
Maryl nd 2 shoule alth and Me 27 Is mark or treumeti	2	19a. Informant's Name/Relationsh Mrs. Joyce Smit			er		ng Address (Stree Park Di					-		
Baltimore, Dermit. Pages 1 ar Department of Hea mportent: If Item: my injury or othe	of relationships for	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (Sp		from State	e   '	reland	sition (Name of natory or other pla Memoria	1	3/4/0		Ba		re, M	Maryland
Balt permit. Departit Importit eny inj		21. Signature of Funeral Service I	En (	au	î		. Name and Addi 5305 Har	ford	Road		mor			nd 21214
	Exam	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	abc.	on each  CA  ue to (or a  ve to (or a	line. 2D//	quence of):  A G G quence of):  R Y	ARR CAI	PY	MI	or respiratory  A  OPA  OSCA	TH	У	· · · · · · · · · · · · · · · · · · ·	Approximate Interval Between Onset and Death ACUTZ-
I Records, P.O. Box 68769.  The law requires that the death certificate to say the law requires that the attending physician bage 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 □ Yes 2 □ No 9 □ Unknown	10	Live birth	ne of pregn 2 ☐ Feti at time of o	aldeath 3□	Ectopic pregnan	су					te of delive	ery Day Year
cords, P. w requires that t	2	Part II. Other significant condition	ns contribution	g to death	$\wedge$	sulting in the u LMONM		iven in Pa	urt I.			co use cont	ribute to th	ne cause of death?
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- S O	lo Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital	1 □ Inpa		ER/Outpatier		ther: 4X	Z.)	th (Check only ome 5 Re 28d. Describ	sidence			v)
Jing After	Certification;	27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  27. Manner of Death  5 Pendin investig investig determ	g pation not be	(Month, E	Day Year)	Injury nome, farm, sti	W	∐Yes 2	□No		(Street	and Numb		ti Route Number,
Divisic To the Hospitel or Attency within 24 hours after death To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier (Check only one) 12 Certifyin 2 Medical	Examiner: On	To the bes the basis d manner	of examin	owledge, deat ation and/or in	h occurred at the vestigation, in my	time, date opinion, o	and place death occu	, and due to the red at the time	e, date	e(s) and ma and place,	anner as st and due to	ated. the cause(s)
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16		30. Name and address of person RoBert E  31. Date filed (Month, Day, Year)	who complete Po	BY	death (Ite M.D strar's Sign	m 23a) (Type,	Print)	RoG	GRZ.	AVE-	BA	ALTIM	RE	204 MD 21209
Stat Registra	-		3 2004	JZ. 700	Sirai s Sign	JA A	balls	~						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ROSE ROSENGARDEN FEBRUARY 28 2004 12:00 P M /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 7211 PARK HEIGHTS AVE. #406 BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV.18, 1907 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ F 216-07-7876 96 Yrs. Director POLAND Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits •how r than "natural", or items 23a or 28a-f ehov the Medical Examinar must be notified at 1 Yes 2 No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7211 PARK HEIGHTS AVENUE #406 21215 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 况 No Specify. WHITE þ 3 ☑ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) VOLUNTEER SINAI HOSPITAL other t permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ISRAEL HAFTKA EVA ROSENWAKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IVAN ROSENGARDEN / 11407 MARBROOK ROAD - OWINGS MILLS, MD 21117 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State HEBREW FRIENDSHIP CEM, 3/1/2004 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensae 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Edwara 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 CI KIM 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician coronan /Medical Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit death certificate be executed physician ar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 3 Probably 4 ∰Unknown 1 ☐ Yes 2 ☐ No Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has page certificate 2□ No 1 Yes 2 No 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Vilhin 24 hours after users.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to the Hospital 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tyle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53968 March 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 CVOSS TUS Sufe 400 Owings MILLS MD 21117 the Goldbloom 31. Date filed (Month, Day, Year) 32.\*Registrar's Signature State MAR 0 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 06657 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 29, 2004 **Physician** ROSENSHEIN 9:00 Рм NORMA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner STELLA MARIS NURSING HOME ME

7. Age (In yrs. last birthday)

Q2 Yrs.

If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | MAR.6, 1920 TIMONIUM BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🙀 F 076-03-9975 NY Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Pages 1 and 2 should be filed within 72 hours after death with the Marylannent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-1 show ury or other traumatic event, I'm Medical Examinat must be notified at 1 Yes 2 No BALTIMORE TIMONIUM Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2300 DULANEY VALLEY ROAD 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify WHITE If Yes, Give Year or Dates: 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **PROPRIETOR** WOMAN'S CLOTHING 18. Mother's Name (First, Middle, Maiden Surmame) 17. Father's Name (First, Middle, Last) Be **JOSEPH** SILVER ROSE (UNKNOWN) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 HARBORVIEW DRIVE #2301 - BALTIMORE, MD 21230 NEIL ROSENSHEIN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 XBurial 2 Cremation 3 XRemoval from State NEW MONTEFIORE CEM. 1 4 ☐ Donation 5 ☐ Other (Specify) 3/2/2004 PINELAWN, NY 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Edural 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Ci 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1.166.16 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequent Examiner Sequentially list conditions, Due to 19 a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and I-transit the death certificate be executed Due to (or as a consequence of) attending physicien a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy 1 Live birth Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 2 No has page certificate 1 ☐ Yes Division of Vital director. 25. Was case referred to medical 26. Place of Death (Check only one) Be axaminer? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; After 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 053283 U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Henry Staget Bethanie 170 21230 31. Date filed (Month Day, Year) 70 32. Fegistrar's Signature State MAR 0 3 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 06658 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 10:15 AM Myrtle Estella Raines February 23, 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Baltimore Unit 202 Rosedale 2017 Kelbourne Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Days Months Hours 1 ☐ M 2X F Yrs March 28,1914 Maryland 89 Director 219-07-0193 Usual Residence of Decedent 10d. Inside City Limits deeth with the Marylend 10c. City. Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylen Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examination must be notified at once. 1 Tyes 20 No Director Rosedale Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21237 United States 2017 Kelbourne Road Unit 202 Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ∐Yes 2 ½No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced White led 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Complet Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Goodwin Frederick Bellman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2017 Kelbourne Road Unit 202 Rosedale, MD 21237 Mr. Clarence Raines / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 2/25/2004 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rertorated Celon 10 days **Physician** during The state of the s /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and the for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification; To within 24 hours atter uses...
To the Funeral Director: After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Colon perfect of during colones cop1

Diction

281. Location (Street and Number or Rural Route Number,
City or Town, State) Injury 1 Natural 5 Pending 2 X No 1 Yes Feb 10,2004 investigation unlesson 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 3001 S Hanover Buthwore, MA Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D39460 25 tc.sart 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BURET-C. 60 Durt 31. Date filed (Month, Day, Year) MAR 0 3 2004 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar 06659 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month ,<sup>Day</sup> 2004 Feb. Lillian 27 Salmond /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1319 N. Montford Avenue Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 25 F 72 Director 212-28-5089 Yrs. 2,1931 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits rai', or itams 23a or 28e-f shov Examiner must be notified at Director fX Yes 2 □ No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1319 N. Montford Avenue 21213 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 27 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Dietary Nutririonist Hospital 12th othert 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental Clarence A Johnson Sr. Dorothy Mae Johnson (Edwards ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Boykin Salmond (Husband) itam 27 i 1319 N. Montford Ave.Baltimore, Md. 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Importent: If its any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 3/6/04 King PK 21. Signaturg of Funeral Service Licenses 22. Name and Address of Facility Tri-State F/S/Inc. 912 Third St.NW., Wash.D.C. 20a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** etastatic Cance disease or condition resulting in death) 7\_ month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ) i a autopsy performed? page 2 certificate 1□ Yes 2√ No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland Vara OMD 1000 E. Eager 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 3 2004 Registrar

			1 - For State Registrar		ryland / Depa <i>Cei</i>	rtificate of	Death	F	Reg. No.	004	06660
	Physicia		1. Decedent's Name (First, Middle, Las Robert	edwin	Shree	eve .		2. Date of Dea Month Februar	Day	, 2004	3. Time of Death 8:35 P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			or Location of Deat	h		ounty of Death	
	- uneral Director		Casey House 5. Social Security Number 217-09-6199	X M 2□F	(In yrs. last birthday)	Rockvi  If Under 1 Year  Months Days		8. Date of Birth (Month, Day April 1.	h v. Year)	ontgome 9. Birthp Court Ma	ry lace (State or Foreign try) ryland
and	3		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
Maryl	e pell	tor	Maryland Montgom	ery	Gaithe	ersburg					1 ☐XYes 2 ☐ No
ith the	or 28s	Director	10e. Street and Number			10f. Zip Code				n of What Cour	ntry?
eath w	na 23a Enual	Funerai	415 Russell Aven	12. Was Decedent Ex	ver in U.S. 13.	208 Was Decedent of	77 Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No-		S.A. Race - Amend	
urs after d	Department of Heelift and Mental Hygiene. Important: if Item 27 is marked other than "neturel", or Items 23s or 28s-f show important: if Item 27 is marked other than "neturel", or Items 23s or 28s-f show apprintry or other traumatic event, the Medical Enach art must be notified at once.	þ	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces?  1 X Yes 2 □ No If Yes, Give 1 9 Year or Dates:	41-1946	If Yes, specify Cub 1☐ Yes 2🛱 No		to Rican, etc.)		Black, White, Decify: Whi	
72 ho	netur dical i	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occu	during most of wo	rking		of Business/In	dustry
within	than than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	<i>DO NOT use retire</i> anical En				lding S	ystems
e filed	other vent, I	Be C	17. Father's Name (First, Middle, Last)		1100110			me (First, Middle,			<u> </u>
ould b	Menta	ToE			eeve	Address (Stmo	I da		kermar		Code)
Man d 2 sh	ith and 27 is m traum		19a. Informant's Name/Relationship (1)  Patricia H. Sh	reeve Wi		Russell A					aryland
s 1 a	Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo			Date		tion - City or To	
Peg .	tment tant: If jury o		4 Donetion 5 Other (Specif)	')	Lorraine			2-2004	Balt	imore,	Maryland
Per Ca	Depar Impor any in		21. Signature of Funeral Service Licen	m		2. Name and Addr 1050 Yor	k Road	uck Towson,	Mary	neral H land 2	ome, Inc. 1204
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	dications that caused to one cause on each line	the death. Do not en e.	ter the mode of dy	ing, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
	ysician Medical		Immediate Cause (Final disease or condition resulting in death)		atic carci	noma					months
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nted	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infriated events	Due to (or as a	consequence of):						
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	ng phy. as the	Ψ.	IF FEMALE:	V							
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that th	ed by detac		Part II. Dther significant conditions c	ontributing to death bu	t not resulting in the u	underlying cause g	iven in Part I.	23e. Did to	obacco use	contribute to the	he cause of death?
w requires	should be	ed by						1 🗆 1	res 2∭∏1	No 3 ☐ Prob	pably 4 □Unknown
e law re	page 2 sho	Completed						24a. Was autop		24b. Were auto prior to co death?	psy findings available mpletion of cause of
	certificate rector, pag	e Cor	25. Was case referred to medical				26 Place of De	1 ☐ Yes	2 <b>X</b> (No	1 ☐ Yes	2□ No
<b>GB</b>	directe	To B	examiner? 1 ☐ Yes 2 🂢 No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatie	nt 3□ DOA O		Home 5 Resid		Other (Specif	Hospice
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JIVISION or Attending	after death. Director: A I in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, farm, st . (Specify)			28f. Location (S City or Tox		Number or Rura	al Route Number,
Hospitel	within 24 hours after death To the Funerel Director: completely filled in by the	edical Co		ysician: To the best on the basis of and manner state	examination and/or in						
To the	within To the compl	Me	29b. Signature and title of certifier	, _/ ,_		29c. Licer	nse number		29d. Date s	signed (Month,	Day, Year)
				Zib			470		Febru	uary 27	, 2004
1	145		30. Name and address of person who E. P. Libre, M.D		oath (Item 23a) (Type onnecticu		Konsin	gton, Mai	cvland	d 2089	5
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registra	de Olementure	AVEILLE	WC113 LIL	g con g rial	JIGH	2003	<u> </u>

		-	1 - For State of Maryland / Department / Department / Department / Department / Department / Dep	artment of Health and Martificate of Death	ental Hygier	ne 2004	
	Physicia	an I	1. Decedent's Name (First, Middle, Last) Gladys R. Stallin		2. Date of Death Feb. 27,	Day 2004 Year	3. Time of Death  11:00p M
Je	/Medic	al -	Gladys R. Stallin  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	J
	Examin Funeral	Ĭ	Continuum Care  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Sykesville If Under I Year   If Under 24 Hrs. Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea Jan. 16,	Carroll 9. Birth	place (State or Foreign ntty) y Land
	Director		219-12-2754 1 M 2 K 92 Yrs.  Usual Residence of Decedent		Jan. 10,	1912 Mary	yrand
	yland how		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits 1 ☐ Yes 2 🛱 No
	Be-f	ctor	Maryland Carroll Westmins			Siii (118 + S	
	23a or 21	ai Dire	10e. Street and Number 764 Washington Rd	10f. Zip Code 21157		USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, Ite Madical Explicat must be natified at ance.	by Funerai Director	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2점 No <i>Specify:</i>	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: WI	
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altimore,	ages int of h t: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)			
altin	nit. Partme orten injur;		21. Signature of Funeral Service Licensee	ark Cemetery 3/3/0 2. Name and Address of Facility Lou	idon Park	Funeral H	lome
ã	Departing Department of the partment of the pa			3620 Wilkens Ave.,			
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	ter the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
ſ	/Medical Examiner		Due to (or as a consequence of):	0.>			
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	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Universitying Cause (Disease or injury that initiated events cause)				
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	To the within 2 To the complete	Me	29b. Signature and Utility of derittion MD	29c. License number D - 8054	218 =	Date signed (Month	-04
_	4		30. Name and address of person who completed cause of death (Item 23a) (Type DR Kerney 34	7 Moderaly Olli	e, Well	t Winsty 1	121159
	Sta Regist		31. Date filed (Month, Day, Year)  MAR 0 3 2004  32. Registrar's Signature	books			

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100	Physicia /Medic		Decedent's Name (First, Middle, La GENEVIEVE	М.	SHEE	IAN			2. Date of D Month Februa	D	<sup>y</sup> ear 27, 2004		e of Death  A M
	Examin	er	4a. Facility Name (If not institution, giv					Location of Dear	h	4	lc. County of Dea		
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036	within 72 hours after death with the Maryland iene. rthan "naturel", or Items 23a or 28a-f show Ite Medical Exam at Host be multed at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:	J.S. 13.		cedent of Hi specify Cuba s 2 🗓 No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or Note Rican, etc.)	10-	14. Race - Am Black, Wh Specify:		l,
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ylan	be pd e	To Be	Harold Char	man				Lor	etta		So	mmers	
	Tie T		19a. Informant's Name/Relationship (Harold D. Sheehar					nd Number or Re reet, Pa				Zip Code)	
Baltimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specifi	Removal from State	Place of Dispo cemetery, crea vview (	matory o	or other place	· .	Date		Location - City of $1 {\sf timore}$		)
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760,	ate be executed sysician and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consect  Due to (or as a cons									
89	tificate ng phys as the		ween the second	d									
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۵.	w requires that the been signed by should be detact	۵	Part II. Other significant conditions c	ontributing to death but not res	sulting in the u	nderlyin	g cause give	n in Part I.		tobacco Yes 2	use contribute to		of death?
al Records,	10	Completed							24a. Wa auto peri		death?	completion o	gs available cause of
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	ding Phys h. After this funeral di	on: To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		28c. Injury Work	4 U Nursing H	ome 5 Res 28d. Describe		6 🕅 Other (Spe ury occurred	cify) at	scene
Division of	l or Attending after death. Director: Aftel in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be			M eet. fact	1 🗆 Y	es 2 □No	28f. Location	(Street a	nd Number or Ri	iral Boute Ni	umber
<u>S</u>	E Sign		4   Homicide	building, etc. (Speci	y)				City or To	wn, Stat	'e)		
	To the Hospitel within 24 hours a To the Funerel C completely filled	edicai	29a. Certifier (Check only one)  1 Certifying Ph	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death ation and/or in	occurre estigati	ed at the tim on, in my op	e, date and place inion, death occu	, and due to the rred at the time	cause(s , date an	s) and manner as id place, and due	stated. to the cause	<b>ə</b> (s)
)	To ti To ti comp	ž	29b. Signature and title of certifier	100 R!		2	29c. License	o.C.M.E	•		ate signed (Mont		
	10		30. Name and address of person who	completed cause of death (Iter			Do	74	D 71.			1 0400	.1
v <sub>j</sub>	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signa		111	renn :	Street,	Raltimo	re,	Marylan	1 2120	1
	Registra	ar	MAR 0 3 200	Figure Sa	1000								

State of Maryland / Department of Health and Mental Hygiene 2004 06663 Certificate of Death

Physician	
/Medical	
Examiner	

Funer

Direct Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked othar than "natural; or Items 23a or 28a-1 show any fujury or other fraunatic event, its Marical Exprining runs he notified any injury or other fraunatic event, its Marical Exprining runs he notified as

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: , completely filled in by the f

J	1 - For State Registrar	State of Maryla	Ce	rtificate	of Deat	h	Re	g. No.	004	
ian	1. Decedent's Name (First, Middle, Las.						2. Date of Deat Month	Day	Year	3. Time of Death
eal er	Aino Jole Stoja  4a. Facility Name (If not institution, give			4b. City, T	own, or Location		February	T -	2004 nty of Death	6:18 A. <sup>M</sup>
	Frederick Villa N 5. Social Security Number 6. Se 106-24-7040		: last birthday) Yrs.	If Under	tonsvil Year If Undo Days Hours	er 24 Hrs.	8. Date of Birth (Month, Day, 09/15/1	Year)		re blace (State or Foreign htry) stonia
	Usual Residence of Decedent						09/13/1	.922		
<b></b>	10a. State 10b. County	10c. C	ity, Town or Lo	ocation					1	Od. Inside City Limits
ecto	MD Baltimo	re	Car	tonsvi						1 ☐ Yes 2 No
ă	10e. Street and Number			10f. Zip			10	og. Citizen o	of What Cour	ntry?
erai	807 Woodside Road	12. Was Decedent Ever in I	115 13	Was Deced	21228		acity Voc or No		nian ace - Amend	an Indian
Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	)	If Yes, speci			ecify Yes or No- Rican, etc.)		lack, White,	
eted	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual	Occupation	ost of worki	na	6b. Kind of	Business/In	
mpi	Elementary/Secondary (0-12)	College (1-4or 5+)			done during me retired)					-
ပိ	12 17. Father's Name (First, Middle, Last)		Sel:	f-Emp1	- /	her's Name				nufacturer
To Be	Arno Lepp	0:4					(First, Middle, N			
	19a. Informant's Name/Relationship (T	ype, Print)					il Route Number,			Code)
	Nick Jole '/Son 20a. Method of Disposition	20b.	Place of Dispo	sition (Name	ide RD		timore,		228 n - City or To	own. State
	1 DBurial 2 Cremation 3 1	Removal from State	cemetery, crer	matory or oth	ner place)				•	
	21. Signature of Funeral Service Licens	ıDu.	laney V	1.5	Mem.		3/2004	l'imon:	ium, M	D
	P. M. M. H	01	Si	terlin	g Ashto	n Sch	wab Fune Baltimo	ral H	ome,	nc.
	23a. Fart1. Enter the disease, or comp shock, or hear failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that aused the dealer cause on each line.  Broncho-pne Due to (or as a conse	ith. Do not ent	er the mode						Approximate Interval Between Onset and Death en days.
	Sequentially list conditions	b. Stroke							Y	ears.
inei	Sequentially list conditions, any, backing to kinh ediate cause. Enter Undertying Cause (Disease or injury	Dire to (or as a conse								
edical Examiner	that initiated events resulting in death) Last	Due to (or as a conse							Y	ears.
Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pre			YADA		Date of delive Month	ory Day Year
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Complet						<del></del>	24a. Was an autopsy perform	24b ed? [2] No	prior to condeath?	osy findings available npletion of cause of 25 No
Be	25. Was case referred to medical examiner?	Hospital:				ce of Death	(Check only one	)		
2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatient 2	ER/Outpatien				ne 5 🗆 Resider			)
cation	27. Maillet of Death 1 ⊠ Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	c. Injury at Work? 1 ☐ Yes 2 [	□No	28d. Describe how			
Sertif	4 Homicide determined	28e. Place of Injury - At Inbuilding, etc. (Special	rfy)	eet, tactory,	UITICO	2	28f. Location (Stre City or Town,	State)	nuer of Hura	i Houte Number,
Medical Certification;	29a. Certifier Certifying Phy 2U Medical Example (One)	sician: To the best of my kn mer: On the basis of examin- and manner stated.	owledge, death ation and/or inv	n occurred a vestigation, i	the time, date a n my opinion, de	and place, a	and due to the car ad at the time, da	use(s) and note and place	nanner as sta e, and due to	ated. the cause(s)
W	29b. Signature and title of certifier	llert		29c.	License number				ned (Month, L	2004 •
	30. Name and address of person who on N B Vellanki, MD;	ompleted cause of death (Ite 9055 Chevrole	m 23a) (Type, et Driv	Print)	100, El]	icott	City, N	1D 210	042.	

State Registrar

31. Date filed (Month, Day, Year) MAR 0 3 2004



**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 08664 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEB. **Physician** 24 2004 THOMAS CONSTANTINE STRATES 6:00p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2001 MT. CARMEL RD. PARKTON BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Days Hours | Min. | 09/11/1929 9. Birthplace (State or Foreign Country) NEW YORK 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 ☐ F 017-22-4945 74 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural', or Iteme 23a or 28a-f show any injury or other traumatic event, I'm Medical Evanciant must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 Yes 2 No MD BALTIMORE PARKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2001 MT. CARMEL RD 21120 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 124 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4YRS Elementary/Secondary (0-12) BUDGET ANALYST BUDGET ANALYST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MANASIS J. STRATES TRIANDIFA PAPAEVANGELOU 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSE ROOT (DAUGHTER) 2001 MT. CARMEL RD. PARKTON, MD. 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 03/01/2004 ROCKVILLE,MD. 4 Donation 5 Other (Specify) GATE OF HEAVEN 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO.
16924 YORK RD MONKTON, MD. 21111 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** he) /Medical Due to Examiner Ware Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ue to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 No 1 Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and two of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRIEDMAN M.D. 222 COLDSPING LANE BALTO., MD 21210. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 03 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $200 \, \mu - 06665$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>0</sup>2004 **Physician** March 1, 1.20 Mark Edwin Stern /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Harford Gardens Nursing Home Baltimore City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F 219-10-9464 Director 76 June 26, 1927 Pennsylvania Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-1 show the Medical Examiner must be notified at Mary land **Baltimore** 1 ☐ Yes 2 ☐ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 4013 Woodlea Avenue USA or items 23a 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 2 No fYes Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 4 College (1-4or 5+) than Elementary/Secondary (0-12) Food Service Food Industry other permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Stern Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy M. Stern/Wife 4013 Woodlea Avenue Baltimore Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Corp. \*4 ☐ Donation 5 ☐ Other (Specify) 3/2/04 Towson Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility Baltimore, Maryland 21214 once Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical the as the attending IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signification can be carried to be carried t 3 ☐ Probably 4 ☐ Unknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Tes 2 No Medical Certification; To 4X Nursing Home 5 Residence 6 Other (Specify) Director: After this in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 Tyes 2 TNo Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29b. Signature and title of certifie 29c. License number 30. Name and address of berson who completed cause of death (Item 33a) (Type, Print) 360 xoen 31. Date filed (Month, Day, Year)

State Registrar 32. Registrar's Signature

		4	For State Registrar	State of Mar	yland / [	Department of I Certificate of	Health and I Death	Mental Hy	giene Reg. No.	2004	06666
100	Physicia /Medic	an	1. Decedent's Name (First, Middle, Las Katherin		lina			2. Date of De Month	M (	2004	3. Time of Death 7 \ 30 Q M
8 J. S.	Examin Funeral Director	er	4a. Fecility Name (If not institution, give School Security Number 6. S 214-01-1454	laris	In yrs. last bin	Tim	O N UW  If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di June 2,	rth ay, Yeer)		lace (State or Foreign try)
	ט		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town	n or Location					0d. Inside City Limits
	Maryli	to	Maryland Baltimore		Spark:	S					1 Tes 2 No
	or 28e	Direc	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Coun	try?
	Seath v	Funeral Director	44 The Strand	12. Was Decedent Eve	er in U.S.	21152	Hispanic Origin? (S	pecify Yes or N	o- 1	USA 4. Race - America	
920	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow fa Medical Examinar mual be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No		o Hican, etc.)		Black, White, e	
21215-0036	72 ho natura	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of wor	rking	16b. Kir	nd of Business/Ind	lustry
121	iene. r than	ошр	Elementary/Secondary (0-12)	N/A College (1-4or 5+)	Hon	nemaker	, , , , , , , , , , , , , , , , , , ,		Own H	lome	
b	al Hyg d other	Be C	17. Father's Name (First, Middle, Last)	-			18. Mother's Nar		, Maiden :	Sumame)	
Maryland	d Ment d Ment marked matic	٥	Joseph Porpora  19a, Informant's Name/Relationship (	Type Print)	19b	. Mailing Address (Stree	Grace Dal		er, City or	Town, State, Zip	Code)
S	alth an 27 is or		Grace S. Myers/Daught			14 The Strand	Sparks, Ma		1152		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28e-f show any rightry or other treumatic event, it a Marical Examinat must be inclifted at ORGE.		20a. Method of Disposition 1XX Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif		cemete	Disposition (Name of ry, crematory or other pla holy Redeemer	3/4/0	Date 14		cation-City or To timore Mar	
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service Licer	See Christina L	. Hilton	n 22. Name and Addr Leonard J. 5305 Hartor	ass of Facility Ruck Inc. d Road Ball	timore Ma	ryland	21214	
68760,5	Physician / Medical Examiner	dicai Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediete Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 / / /	atic consequence consequence	Merkle of):	/ 11 /	CAY ( 1 Y)			Approximate Interval Between O set and D ath
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Δ.	uires that t signed by id be detae	by	Part II. Other significant conditions of	contributing to death but	not resulting i	n the underlying cause g	iven in Part I.		tobacco u	se contribute to th ∇No 3 ☐ Prob	ne cause of death?
Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed						24a. Waauto peri		24b. Were autor prior to con death? 1 ☐ Yes	psy findings available impletion of cause of 2 X No
Vital	Physicien: This certificatral director, p	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of De				
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	spita hours ineral y filled	edical C	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	nysician: To the best of miner: On the basis of e and manner state	examination ar	e, death occurred at the nd/or investigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time	cause(s) , date and	and manner as st place, and due to	ated. the cause(s)
	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier	10	11	29c. Licer	nse number	, _	29d. Date	e signed (Month, i	. 3
	1		F mestin	e W	nght	D	527	40	11/0	wch 1	1 SOOK
	5		30. Name and address of person who ERNESTINE WRIGHT		- 1	(Type, Print) NEY VALLEY I	ROAD TIM	ONIUM,	MD 21	093	
		ate	31. Date filed (Month, Day, Year)	32. Registrar		& Sarah E					
	Regist	rar		F19114 2.98	and the state of	8 Barel 8					

2004

MARCH 1,

KATHERINE SALINA

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 1 - State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:10P M **FEBRUARY** 2004 SCHWARTZ ELAINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner JEWISH CONVALECENT & NURSING HOME BALTIMORE BALTIMORE 8. Date of Birth (Month, Day, Yeer) 06/08/1913 If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 □ F CONNECTICUT 90 Director 051-05-5243 Usuel Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral', or items 23a or 28e-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No BALTIMORE Director MD BALTIMORE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 U.S.A. 7920 SCOTTS LEVEL ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: ۵ 3X Widowed 4 □ Divorced WHITE "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) WHOLESALE DRUGS ADMINISTRATOR other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Nem 27 is marked oth eny injury or other treumatic event apre. 17. Father's Name (First, Middle, Last) **SCHLOSSMAN** BERTHA ROSENBLOOM NATHAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21117 3304 NANCY ELLEN WAY OWINGS MILLS MD. SANDY SACKI / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/1/2004 BETH TFILOH CEMETERY WOODLAWN \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN RD. BALTIMORE MD 21208 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest show, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death ALZ Immediate Cause (Final disease or condition resulting in death) MERS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 2 Fetal death Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 100 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. pe 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) 24a. Was an certificate has 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Hospitel or Attending Physicien: Be 26. Place of Death (Check only one, Other: Hospital: 2 1 No 4 DNursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c, Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No М 2 Accident within 24 hours after deat To the Funerel Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 - Homicide 1tt Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tite of certifier ss of person who completed cause of death (Item 23a) (Type, 30. Name and addr M 32. Registrar's Signature 31. Date li State Registrar 200

4-01542 AN		Please I  1 - State Registrar AMEND ITEM #19	State of Ma	aryland / Dep 29-3/04/0/Ce	artment of I	lealth and l	-	giene	_	0666
Fr. words, our charge		Registrar ATICALO TITTA IF 196     Decedent's Name (First, Middle, Last)	a the in Go	27 370-70-00	rimodio or	Dodan	2. Date of De			3. Time of Death
Physic		DAVID GENI	E SCHWI	FINDY			Februa	ary 29	, 2004	2234 P M
/Medi Exami		4a. Facility Name (If not institution, give s						-	ounty of Deeth	
- VALUE AND	9.5 95	Good Samaritan Ho	spital		Balt	timore N/A				
Funeral		Social Security Number     6. Sex		e (In yrs. last birthday	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di	rth ay, Year)	9. Birthp	place (State or Foreign ntry)
Director		070-30-3923	M 2□F	56 Yrs.			Apr 24	, 194		York
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
Aaryli Paho	ō	Maryland Baltimore	County	Idlev	v1de					1 ☐ Yes 2 💢 No
the t	rect	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	ntry?
3a or	0	6318 Banbury Road			2	21239			USA	
death ms 2	by Funeral Director		12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of I		pecify Yes or No	0- 14	Race - Americ Bleck, White,	
6 after or he	E	1 Never Married 2 Married	1  Yes 2 ☐ ! If Yes, Give	Vo.	1 ☐ Yes 2 ☐ No		101110411, 010.7		ancihe:	
ours ural;	d b	3 X Widowed 4 ☐ Divorced	Year or Dates:		Λ				MIT	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 ahow any injury or other traumatic event, the Modical Exercities trained by inclinical at 1000s.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5	(Give	edent's Usual Occuj e kind of work done DO NOT use retire	during most of wor	rking	16b. Kind	of Business/In	dustry
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Maryland nd 2 should be file lith and Mental Hy tra Is marked oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	TIO (FIFST, MIGGIE	, Maideri St	imame)	
aryla should and Men	To	Clifford Ezra Sc 19a. Informant's Name/Relationship (Ty	no Print)	10h Mail	ing Address (Street	Phy11:	is Earl	ldine	Stantor	Code)
Mal d 2 st th and 7 Is r		STEVEN M. SCHWENDY (SO Stephen M. Schweng	N) (Son							
Healing		20a. Method of Disposition	ly ( <del>3011</del>		Banbury osition (Name of omatory or other pla	Road, ba.	Date		tion - City or To	
noi ages ant of tr: # If		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	lemoval from State		omatory or other pla ount_Ceme:	1	12004	Delta	December 1	Manus Tanad
Baltimore, Dermit. Pages 1 ar Department of Hea Important: If Item any injury or othe		21. Signature Funeral Service (cens	69	2	2. Name and Addre	ess of Facility				Maryland
Balt permit. Depart Import					Mitchell-	Wiedefeld	d Funera	1 Hom	e, Inc.	21212
Physician /Medical		Martin D. Laws  23a. Part1. Enter the disease, or complete shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Hyperten	the death. Do not enember sive Arter a consequence of):						Approximate Interval Between Onset and Death
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):						
8760, ate be executed hysician and the burial-transit	<u>a</u>	resulting in death) Last	Due to (or as	a consequence of):						
vision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certificate redeath. ector: After this certificate has been signed by the attending phys by the tuneral director, page 2 should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant al 9□Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y		236	d. Date of delive	ery Day Year
rds, P.		Part II. Other significant conditions con	ntributing to death b	out not resulting in the	underlying cause gr	ven in Part I.			contribute to t	he cause of death? bably 4 Junknown
Division of Vital Records, at or Attending Physician: The law requires tater death.  Director: After this certificate has been signed in by the funeral director, page 2 should be come.	Completed							s an in	24b. Were auto prior to co death? 1 \( \sum \text{Yes} \)	opsy findings available impletion of cause of
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Division of Vital Re or Attending Physician: The litter death. Director: After this certificate he in by the funeral director, page	atlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ury 28b. Time ly Year) Injury	Wo	iryat ork? ]Yes 2 □ No	28d. Describe	how injury o	occurred	
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To the within 2 To the comple	₩	29b. Signature and title of certifier			29c. Licen	se number		29d. Date :	signed (Month,	Day, Year)
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/.	0	30. Name and address of person who co			a, Print) .1 Penn St	treet, Ba	ltimore	, Mary	land 2	1201

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

			For State Registrar	State of Maryla	nd / Departme Certifica	nt of Health and te of Death	Mental Hygier	_ C U U 4	06669
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Las JEAN A 4a. Facility Name (If not institution, give	. WILS		YLOR y/Town, or Location of Dea	Februar	Pay Yeer Yeer 27 2004	3. Time of Death
	Funeral Director	GI	NORTH ARUNDE 5. Social Security Number 6. Si 256-60-9090 1	L HOSPIT	A L (-) I ast birthday) If Unontrol A Yrs.	er 1 Year   if Under 24 Hr		A. A. County 9. Birthpi	ace (State or Foreign try) ORGIA
	Maryland	tor	Usual Residence of Decedent  10a. State  10b. County  MARVIAID A. A. (	100.0	ity, Town or Location	EN BUI	2 NIE	11	0d. Inside City Limits 1 ☐ Yes 2 💢 No
	rs after death with the Marylan I', or ttems 23a or 28a-f show	Funeral Director	10e. Street and Number 192 MORRIS		ENUE	2/0	60	Citizen of What Coun  USA  14. Race - Americ	t ·
12 P	ours after de al', or item	þ	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	i	edent of Hispanic Origin? (pecify Cuban, Mexican, Pue	rto Rican, etc.)	Black, White, Specify: BL	
1215-0	filed within 72 hours after death with the Maryland Hygiene. Hygiene, then "natural", or items 23s or 28s-f show ont, the Medical Evaluation must be treitined at	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NO	vork done during most of w use retired)	orking	Kind of Business/Inc	Haspital
/ /	should be filed nd Mental Hygi marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last)  ARTHUR		LSON		ame (First, Middle, Maid	en Surname)	IES
FEAT Man	1 and 2 sh Health and tem 27 is m		19a. Informant's Name/Relationship (1)  CLARENCE L. TA  20a. Method of Disposition  1 ★Burial 2 □ Cremation 3 □	PYLOR (HUSBAN) 20b.	Place of Disposition (I cemetery, crematory)	lame of r other place)	L AVE. GLA	y or Town, State, Zip EN GURNIE, Location - City or To	MD21060
Baltimore	permit. Pages Department of I Importent: If it, any injury or o once.		4 □Dopation 5 □ Other (Specification of Funeral Service □ Door		22. Name	and Address of Facility	-03-04 CR ROWN JK ON AVE., A	CLUMSVILLE C. FUNER BALTO, M	MARYLAND CAL HOME O 21217
•	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the dea one cause on each lin .  a. Due to (or as a conse	he tim	ode of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between Onset and Death
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P.O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	ta! death 3 □Ectopic	pregnancy (specify)		23d. Date of delive Month	ny Day Year
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Division of Vital Records.	The law recate has bee page 2 shoo	Completed					24a. Was an autopsy performed	prior to con death?	psy findings available inpletion of cause of
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	he Ho in 24 he Fu pletel	edical	one)	niner: On the basis of examinand manner stated.					
	To ti withi To ti comp	Σ	29b. Signature and title of certifier	3		29c. License number	29d. I	Date signed (Month, I	Day, Year)
	al			n	10	D43777	je	may 2	12004
	9		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, Print)	Cika Bring	ne. Aun	. 2 intal	•
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar 9ig	nature	way way	(NV)	- 1/00/	
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d	State of Maryland / Department of Health and Mental Hygiene Item#23a,27,28a~f, Perij Min G839at3/8/04eg	2004	06670

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Physician	
/Medical	-
Examiner	

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked othar than "naturat; or itams 23a or 28a-f show any injury or other traumatic event, if a Medical Exercise mark be reutified at angule.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - Stete Unpend Item#23a,27  1. Decedent's Name (First, Middle, Last)  JAMES DOUGLAS	TTMMONG				No.  Day Year	3. Time of Death		
cal		TIMMONS	4b. City, Town, or I	acation of Dooth	rebruar	y 25, 200 4c. County of Dea			
ner	4a. Facility Name (If not institution, give street and numbe John Hopkins Hospital		Baltimore			4c. County of Dea	tn		
	213-54-0774 XX <sup>M 2□ F</sup>	oge (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Co	thplace (State or Foreigr ountry)  Bh. D.C.		
7	Usual Residence of Decedent  10a. State 10b. County  MD NA	10c. City, Town or Los BALTIMOR					10d. Inside City Limits		
Director		DALITION			100	021 (110 ) 0	4.		
	3901 Bareva Road		10f. Zip Code 21215	5		Citizen of What Co	ountry?		
Funeral	11. Marital Status 12. Was Deceder Armed Forces	i? #	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi			
ρ	1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates	1	Yes 2X No	Specify:		Specify: B	lack		
ete	15. Decedent's Education (Specify only highest grade completed)	(Give	ent's Usual Occupat		16b	. Kind of Business	/Industry		
Completed	Elementary/Secondary (0-12) College (1-4o 1 yr.	r 5+)	iceman		Δ	rmed Fo	rces		
	17. Father's Name (First, Middle, Last)	0017		18. Mother's Name	(First, Middle, Maid		rces		
To Be	Greeley James Timmons		E	Ella Mae	Harrin	gton			
	19a. Informant's Name/Relationship (Type, Print) Shonta Timmons — Siste		g Address (Street ar Bareva		Route Number, Cit				
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	. Location - City or	Town, State						
	'4 Donation 5 Other (Specify) Garrison Forest Vet. Mar. 4 04 Owings Mills, MD								
	21. Signature of Funeral Service Licensee	\ L	March Fu	neral H	lome Wes	t, Inc.			
	23a. Part I. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	er	4300 War	ash Ave	Balt	O. MD	21215 Approximate		
	Immediate Cause (Final disease or condition resulting in death)  Drowning  a. 'arter	complicationsclerotics a consequence of):	ing hyp	ertensi	ve		Interval Between Onset and Death		
Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	is a consequence of):							
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by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributions								
Completed					24a. Was an	24b. Were au	itopsy findings available		
E					autopsy performed 12 Yes 2	? death?	completion of cause of 2 No		
18	25. Was case referred to medical examiner?			26. Place of Death	(Cleck only one)				
Be Co	examiner? 1 ☑ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☑ €R/Outpatient 3 ☐ DOA  Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)								
To Be	1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpa		3LI DOM	4 Nursing Hon					
To Be	1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpa  27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, C	jury 28b. Time of Injury	28c. Injury a Work?	at 2	8d. Describe how in				
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Certification: To Be	1 Nest 2 No Hospital: 1 Inpa  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  2 No Hospital: 1 Inpa 28a. Date of In (Month, D) 2 / 2 5 / 2	jury Yeer)  28b. Time of Injury  04  unkno njury - At home, farm, streetc. (Specify)  r  st of my knowledge, death of examination and/or invisited.	28c. Injury: Work? 1 Yeet, factory, office  occurred at the time estigation, in my opin  29c. License O.C.M.	at 2 as <b>2CX</b> to  2 a, date and place, a nion, death occurre	subjec  8f. Location (Street City or Town, St  1700blk.  Ind due to the cause d at the time, date:  29d.	t drown and Number or Relate) Thames e(s) and manuferal and place, and due Date signed (Monte bruary 26	St., Standore, Manager of the cause(s) h. Dey, Year) 5, 2004		

			1 - For State Registrar	State of Maryland / I	Department of Health Certificate of Deat	and Mental Hygien h Reg. N	e 2004 0667
	Physici /Medic		Decedent's Name (First, Middle, Last)	Donna Marie T	hompson	2. Date of Death Month D FEBRUAR	ay Year 3. Time of Death 7 25, 2004 4:450M
	Examir		4a. Facility Name (If not institution, give : Saint Joseph	Medical Cent	4b. City, Town, or Location	n of Death 4	c. County of Death Baltimore
	Funeral Director		214-38-0620	7. Age (In yrs. last bir	thday) If Under 1 Year If Under 1 Year Months Days Hours	er 24 Hrs. 8. Date of Birth (Month, Day, Yea) July 24,19	9. Birthplace (State or Foreign Country) Maryland
the Maryland 286-f show	Director	Usual Residence of Decedent	10c. City, Tow		mere	10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Exertinal relational and once.	Funeral	7312 Geise Ave.  11. Marital Status  1 Never Married 2 Married  * Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	2121  13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic  1 \( \subseteq \) Yes 2 \( \overline{\text{X}} \) No \( Specification \)	Origin? (Specify Yes or No- can, Puerto Rican, etc.)	Inited States  14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	ed within 72 hou ygiene. ier than "nature t, the Medical E	Completed by	15. Decedent's Educify only highest grade  (Specify only highest grade  Elementary/Secondary (0-12)  12 Years	cation 16a	Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)  Data Specialist	De D	Kind of Business/Industry Partment of Defense
Maryland	ould be file Mental Hy varked oth	To Be	17. Father's Name (First, Middle, Last)  Arvi S. Koski			her's Name (First, Middle, Maide Elma Tyler	
	and 2 sh leaith and m 27 ls m		Mrs. Lisa L. Fole	/ Daughter	Mailing Address (Street and Num 3505 Sollers Po	int Road Dunda	lk, Maryland 21222
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)  21. Sign has of Funeral Service Licenses	emoval from State cemete. B@l Air			Location - City or Town, State Air, Maryland Dundalk, Inc.
8760,	Physician and // / / / / / / / / / / / / / / / / /	dicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.	RATORY DISTRE		Approximate Interval Between Onset and Death DAYS
.O. Box 6	The law requires that the death certific lie has been signed by the attending p bage 2 should be detached for use as s	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \begin{array}{c} \text{Yes} & 2 \end{array} \) No \( 9 \end{array} \) Unknown	ac. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery  Month Day Year
Records, P.	v requires that been signed b should be deta	þ	Part II. Other significant conditions con DECOMPRESSION LAM	1. 23e. Did tobacco	use contribute to the cause of death?		
al Rec	ician: The law i certificate has bu rector, page 2 sh	Completed	CRONIC OBSTRUCTIV	E PULMONARY DISE	ASE	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1
of K	Phys rthis raldi	n: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death		Other	ce of Death Check onl one  Nursing Home 5  Residence  28d. Describe how inju	
Division of Vital	tendin Jeath. tor: Af the fur	Certification:	1 R Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	nd Number or Rural Route Number, e)			
	To the Hospitel or At within 24 hours after or To the Funeral Directompletely filled in by	edical (	29a. Certifier (Check only one) 12 Certifying Phys	ician: To the best of my knowledge er: On the basis of examination and and manner stated.	, death occurred at the time, date a Vor investigation, in my opinion, de	and place, and due to the cause(s eath occurred at the time, date an	c) and manner as stated. d place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number  D ØØ6 Ø		tte signed (Month, Day, Year)
1/3	Sta Registr		30. Name and address of person who con ZHEN FAN M. D.  31. Date filed (Month, Day, Year)  MAR 0 3 2004		INE TOWSON MA	ARYLAND 21204	,

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 0 0 4 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month 0830A 2 04 4b. City, Town, or Locetion of Death 4c. County of Death 4e Facility Neme/(If not institution, give street end number) acres Narsin Centrapolis If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Days Months 1**X**M 2□ F 89 262-09-2563 Feb. 23, 1915 Florida Usual Residence of Decedent 10c. City. Town or Locetion 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Capital Heights MD Prince Georges 10g. Citizen of Whet Country? 10e Street and Number 10f. Zip Code 9506 Dogwood Park Street 20743 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②CNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married XX Married 1 ☐ Yes ŽXNo Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Ice Cream 12 Salesman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Henry Clay Waters Martha Jamison 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John Mickey (Son-in-law) 412 Granville Road, Riva, MD 21140 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Avenue, Annapolis, MD 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 No 1 Tes 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

Pages 1 end 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ita

Department of Health Important: If item 27 i

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Baltimore, Maryland 21215-0020

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been signed by the attending physician end should be deteched for use as the bunel-transit certificete be executed P.O. Box 68760. The law requires that Division of Vital Records. page 2 should be this certificate hes al or Attending Physician: T sefter death.
i Director: After this certificat ed in by the funeral director, p

Certification:

Examine Physician/Medical ð Completed Be ၉

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical examiner?

1 ☐ Yes 2 No Menner of Death 5 Pending investigation

2 Accident 6 Could not be 3 ☐ Suicide 4 - Homicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 Tursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature title of certifies

29a, Certifier

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Yeer) a

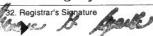
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADITY A

Aditya Chopra, MD, 600 Ridgely Avenue, Annapolis, MD 21401 31. Date filed (Month)

State Registrar

Medical



A Hospital

To the F

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Yeer **Physician** 2:30 P M FEBRUARY 25 VERONICA WHITE 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner CHARLOTTE HALL VETERANS HOME MARY S CHARLOTTE HALL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F MASSACHUSETTS Director 029-20-6394 75 NOV. 24.1928 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic avent, the Medical Executiver must be notified at 1 ☐ Yes 2 🛛 No Director ST. MARY'S CHARLOTTE HALL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 29449 CHARLOTTE HALL ROAD U.S. items 23a 20622 Α, Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1XXYes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes ZŒNo Specify Specify: 3 Widowed 4 Divorced Year or Dates WHITE naturai 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Heelth and Mental Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) OWNER & OPERATOR ANSWERING SERVICE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ပ (UNAVAILABLE) (UNAVAILABLE) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ERNEST E. VOGEL / FRIEND 29449 CHARLOTTE HALL RD. CHARLOTTE HALL, MD 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition FEBRUARY 0 = 5 1 ☐ Burial 2XXX remation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 1 4 ☐ Donation 5 ☐ Other (Specify) BRINSFIELD-ECHOLS CR. 28, 2004 CHARLOTTE HALL, MD 21. Signature of Funeral Service 22. Name and Address of FacilityBRINSFIELD-ECHOLS FUNL.HME., P.A. our Sa 30195 THREE NOTCH RD. CHARLOTTE HALL, 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition MyOCavalla **Physician** resulting in death) /Medical Examiner VOVAV Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of) Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown been sig 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page this certificate 1 Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 1 Yes 2 No Certification: To 3 DOA ivision of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by hours after ŏ To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 24 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 0 3 2004

		State of Maryland / Department of Health ar state-Amend Item 20b per FH, G829, 03/03/04dhb Certificate of Death	nd Mental Hygier Reg.	* 1 1 1 1 1	06674
Physicia	an	1. Decedent's Name (First, Middle, Last)  CARY WAWACE	2. Date of Death	Day Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give street and number), 4b. City, Town, or Location of I	Death	4c. County of Death	1
Funeral Director		217-56-6445 17 M 2 F 53 Yrs. Months Days Hours Usual Residence of Decedent	Min. Month, Day, Ye.	ar) MA	nplace (State or Foreign untry) Rifferd
e Maryland Ba-f ahow Milled at	ctor	MARYLAND WA BALLIMORE			10d. Inside City Limits 1 XYes 2 No
ath with th	Funeral Director	3213 Lindale Avenue 21213		USA	
irs after de	by Fune	11. Marital Status  1  Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Never Married 2 Married  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Force of Yes, Give 1 Yes, Specify:  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Force of Yes, Give 1 Yes, Specify:  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Force or Yes Tables.	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer Black, White Specify: •	American
be itied within 72 hours after death with the Maryland ital Hygiene.  ad other than "natural", or Items 23s or 28s-( show adent, Ira Madical Evanuar must be undified at avent, Ira Madical Evanuar.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Coflege (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	of working	. Kind of Business/I	
b d tal	To Be Cor	, ,	s Name (First, Middle, Maid		are
permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic anges.	-	19a Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Street and Number of S	BAHLMORE, M	Aryband	212/3
Pages 1 at thent of He tant: If item		20a. Method of Disposition  ↑ ☐ 60 rial 2 ☐ Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)	16/07 LA	Sociation - City or T	MARY And
Departit Departit Importit any inji		21. Signature of Funeral Service Licens  22. Name and Address of Facility  23. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  29. Name and Address of Facility  21. Signature of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Na	Klin St. BA	71to, Nel	21229 Approximate
Physician /Medical		show or hear failure. List only one cause on each line.  Immediate Cause (Finat disease or condition resulting in death)  a. BOWEL ISCHEMIA  Due to (or as a consequence of):			Interval Between Onset and Death 4 DAYS
Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
cate be executed physician and the burial-transit	edical Examiner	resulting in death) Last  C.  Due to (or as a consequence of):			
E 0 6		IF FEMALE: 23c. If yes, outcome of pregnancy 1		23d. Date of deli	
~ w ~	Physician/M	n the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobace		the cause of death?
The ate h page	Completed		24a. Was an autopsy performed	prior to o death?	topsy findings available completion of cause of 2000 No
g Physician: The tribicate er this certificate eral director, pag	n: To Be	examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nurs  27. Manner of Death  28a. Date of Injury Yes)  28b. Time of 28c. Injury at Norse	of Death (Check only one) sing Home 5 Residence 28d. Describe how in		cify)
To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S		iral Route Number,
e Hospital 24 hours a E Funeral I etely filled	edical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.			
To the within To the	Me	29b. Signature and title of certifler  MAREPALLY  29c. License number  AT 44385	29d. MF	PRCH, 1,	
6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAPNA MARCPALLY 29 S PACA STREET BALTIME	DRE, MD		
St Regist	ate rar	31. Date filed (Month, Day, Year)  AR 0 3 2004			

	For 1 = State Registrar	State of Maryland	/ Department of Health and Certificate of Death		ne 2004	06675
Physician	1. Decedent's Name (First, Middle,	Last)		2. Date of Death Month	Day Year	3. Time of Death
Physiciar /Medica	LARKERS	aire etropt and sumber)	WHEELER  4b. City, Town, or Location of Deat	March	4c. County of Deeth	900 A M
Examine	Johns Hookins		lanter Baltimore		io. Godiny of Dodin	
Funeral Director	5. Social Security Number 219–26–7542	5. Sex 7. Age (In yrs. last 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		(Month Day V	ear) Cou	place (State or Foreign ntry) cyland
and	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits
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or 28e	Maryland I		10f. Zip Code	"	. Citizen of Whal Cou	•
s 23e			21222		nites Stat	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene series to flems 23e or 28e-f show aumstic event, the Medical Examine must be notified at	7821 Lockwood  11. Marital Status  1 Never Married 25 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (s If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2X No Specify:	to Rican, etc.)	Black, While,	etc.
72 hou	15. Decedent's		16a. Decedent's Usual Occupation (Give kind of work done during most of wo	rking 16	b. Kind of Business/In	dustry
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E dab c	Charles W. Who	eeler	Cath	erine M. C	rf	
> = < > = =	19a. Informant's Name/Relationshi	p (Type, Print) C. Wheeler/Wife	19b. Mailing Address (Street and Number or Ri 7821 Lockwood Road	ural Route Number, C Dundalk,		Code) 21222
E 2 2 2 2	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Sp.	3 □Removal from State	ce of Disposition (Name of metery, crematory or other place) ardens of Faith Cem. 3		c. Location - City or T Rosedale	
Balti permit. Departm Importe any inju	21. Signature of Funeral Service L	C. Canl	22. Name and Address of Facility Duda-Ruck Funeral 7922 Wise Ave. I	undalk. M	arvland 2	nc. 1222
A	23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused the death. nly one cause on each line.	Do not enter the mode of dying, such as cardia	c or respiratory arrest	1	Approximate Interval Between Onset and Death
Physician	Immediate Cause (Final disease or condition resulting in death)	-a. Arrhythmi				10 minutes
/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque	obstructive pulmonar	y discus	e	5 years
Box 68760, V eath certificate be executed attending physician and for use as the burial-transit	resulting in death) Last	Due to (or as a conseque	ence of):			
Box 68 eath certifice attending pt for use as t	F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand			23d. Date of deliv	ery
Vision of Vital Records, P.O. Box 6i Attending Physician: The law requires that the death certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant condition  Cortical Br	1 Live birth 2 Fetal of 4 Pregnant at time of dea			Month	Day Year
cords, P	Part II. Other significant condition	ns contributing to death but not result	ting in the underlying cause given in Part I.		cco use contribute to t	
v requ		WIN DOWN		24a. Was an		posy findings available
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ital	25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)	1.00	20,10
of V hysic this ce al dire	O 1 ☐ Yes 2 X No				e 6 Other (Special	(y)
On C	27. Manner of Death  1 X Najural 5 Pending	(Month, Day Yeer)	28b. Time of 28c. Injury at Work?  M: 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division of Vital Records, or Attending Physician: The law requires that deer death.  Director: After this certificate has been signed in by the funeral director, page 2 should be death.	27. Manner of Death  1 Natural 2 \ Accident   5 \ Pending investigate 3 \ Suicide   6 \ Could not determing	ot be 200 Place of Injury - Al hor	ne, farm, street, factory, office	28f. Location (Stree City or Town,	et and Number or Run State)	al Route Number,
	29a. Certifier 1 Certifying		ledge, death occurred at the time, date and place on and/or investigation, in my opinion, death occ			
within To the	29b. Signature and title of certifier		29c. License number	1	. Date signed (Month,	Dey, Year)
	> Dhidd	mb	RES-000	/	March 1	, 2004
lo	30. Name and address of person we David Riedel mc	who completed cause of death (Item 3	23a) (Type, Print) H65, sital 600 N W			MD 21287
Stat	Od Date filed (March Dev Vere)	32. Registrar's Signatu				
Registra	B B B 95	2004	A Source			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

0			Type or Prir State of Ma				lealth and M	-	_	ible.	
		<b>1 - State</b> Regist <b>Unpend Item#23</b> a,							g. No. 2 (	104	06676
Physici /Medio		<ol> <li>Decedent's Name (First, Middle, Las</li> </ol>	et Walsch					2. Date of Deat Month Februal	Day	Yeer 2004	3. Time of Death  8:55 A <sup>M</sup>
Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of Death		4c. County	of Deeth	
		13125 Sylvan Aven		- // /	Link d 1	Chase	II Under 24 Hrs.	O Date of Righ	Balt		County
Funeral Director			7. Agi □ M 2∑TF	e (In yrs. last b	Yrs.	Months Days	Hours Min.	8. Date of Birth	52 <sup>(1)</sup>		lece (State or Foreign try) ryland
Maryland -f ehow	tor	Usuel Residence of Decedent  10a. State MD Baltin	more	10c. City, To	own or Lo	ocation				1	0d. Inside City Limits 1 ☐ Yes 2 1 No
death with the Maryland me 23a or 28e-f ehow r.must be notified at	Funeral Director	10e. Street and Number 13125 Sylvan Avent	ue	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10f. Zip Code 2122	20	11	0g. Citizen of US		try?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatlan and Mental Hygiene.  Department of Heatlan and Mental Hygiene.  Important: If item 27 is marked other than "natural; or Itame 23a or 28e-1 show any injury or other treumatic event, the Medical Examinar must be notified at any injury or other treumatic avent, the Medical Examinar must be notified at any injury or other treumatic avent, the Medical Examinar must be notified at	by	11. Marital Status  1 Never Married 2 Narried 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Ble	ce - Americ ck, White, y:White	etc.
in 72 ho n "natur Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)			a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	eation during most of work d)	ing	16b. Kind of B	usiness/Inc	dustry
d with giene ar tha	E	12	0	,*,	Hon	emaker			Own 1	Home	
uld be file Aental Hy rked other tic event	To Be C	17. Father's Name (First, Middle, Last) John Schuler					18. Mother's Name Mabel Do	e (First, Middle, M $011\mathrm{y}$	Maiden Sumar	ne)	
nd 2 sho atth and h 27 is ma ir treuma		19a. Informant's Name/Relationship (7 Robert A. Walsch				ng Address (Street Sylvan 1	and Number or Rura Avenue Cl	al Route Number, hase Mar			Code)
Pages 1 a lent of Hea nt; If item ry or othe		20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □ '4 □ Donation 5 □ Other (Specify		cemet	tery, crei	sition (Name of matory or other place Matory	ca)	) 2004	Cato		wn, State le, MD.
permit. Departmine importe any inju		21. Signature of Europat Service Licen	see		1	2. Name and Addre	ss of Facility Cvac aco Avenue	ch/Rosed e Roseda	ale Fur le Mar	neral yland	Home 21237
503		23a. Partt. Enter the disease, or comp shock, or heart failure. List only									Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ve Ather		erotic Card	iovascular l	Disease			Onset and Death
Examiner		Sequentially list conditions.	b								
executed in and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequenc	is of):						
bur bur		resulting in death) Last	Due to (or as	a consequence	e of):						
certificate nding phys use as the	edic		. u.								
0 0	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)	/		1	ite of delive onth	ry Day Year
law requires that the dias been signed by the 2 should be detached	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting	g in the u	nderlying cause giv	en in Part I.		acco use con		e cause of death?
has has	Completed							24a. Was ar autops perform	y ned?	Were autor prior to con death? 1 \$\mathbb{E}\$Yes	osy findings available inpletion of cause of
icien; Th certificate rector, pag	0	25. Was case referred to medical					26. Place of Deat			102103	20110
lis d	To B	examiner? 1 🔀 Yes 2 🗌 No	Hospital: 1 Inpatie	ent 2 ER/C	Outpatier	nt 3 DOA Oth	er: 4 Nursing Ho	me 5 🗆 Reside	nce 6 200	ner (Specify	At scene
iding Pt th. : After th funeral		27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year) 28b	). Time o Injury	Wor		28d. Describe ho	w injury occur	red	
To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et		larm, str	reet, factory, office		28f. Location (Str City or Town		per or Rura	Route Number,
Mospita 24 hours Funeral etely fille	edical C		ysicien: To the best niner: On the basis o and manner sta	f examination a							
To th within To th compl	Me	29b. Signature and title of certifier	u .	140		29c. Licens		29	9d. Date signe	d (Month, E	Day, Year)
		30. Name and address of person who	completed cause of d	1	D (Type	O.C.M	.E.	F	ebruar	y 24,	2004
5		Taisha Z Giv	cenhera	M.D	),		Street,	Baltimor	e, Mar	yland	21201
Sta Regist	ate rar	31. Date liled (Month, Day, Year) MAR 0 3 2004	32. Registr	ar's Signature	flag.	could					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Feb Day **Physician** 23:34 M 29,2004 Son Ho /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia Howard County General Hospital Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Mar. | 15, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1**⊠**M 2□F 1929 215-76-0780 74 Korea Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 ∏Yes 2X No Directo Maryland Ellicott City Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or iteme 23e 21042 United States Fox Den Court 10028 Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Asian 3 Widowed 4 Divorced Year or Dates: naturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "na eny injury or other fraumatic event, Ira Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Wholesaler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Sung Jumbok Park 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Yi Bruce \_ Son 7263 South Ora Court Greenbelt, Maryland 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition ¥28urial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 3/4/04 Elkridge, Maryland Gary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075 21. Signature of Funeral Service Licenses Msk. Hademan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** cars /Medical resulting in death) **Examiner** Saguantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) attending physician P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Day Year 4 Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records, 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical example?

1 Pres 2 No funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 PER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funerel Direct completely filled in by filled in by 4 Homicide To the Hospitel To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 10 20012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemlock Cone Way PATRYCE A. TOYE, MU 45G5 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygien ? 06678 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** ZEPHTR **VERA** 28 EB 10:07 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURECARE OF THE CHESAPEAKE ARNOLD ANNE ARUNDEL CO. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Nov. 16 19 Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 220-20-3136 77 1926 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exeminer must be nutified at 1 Yes 2 □ No Completed by Funeral Director Md. n/a Baltimore the 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 9 1812 Byrd Street 21230 U.S.A. or items 23a filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ↑ Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify: white Specify 3 ₩ Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ouinby Fitzhugh E11a Malinda Charles Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1602 Tieman Drive, Glen Burnie, Md. 21061 Jeanette Moulton (Dgt.) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery | 03/03/04 Baltimore, Md. 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A
130 E. Fort Ave. Baltimore, Md. 2 21. Signature of Funeral Service Licenses Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of): Examiner DYSPHAGIA EVERE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2: ☑ No Month 5 Other (specify) page 2 should be detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Fobably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No FAILURE TO THRIVE autopsy performed? this certificate 1 Yes 2 ₽ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4. Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 PNo Medical Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D57531 FEB 28, 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Veterons Highway # 204 MILKISVIK ND 21108 Ness 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 3 2004

State of Maryland / Department of Health and Mental Hygieney 06679 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MILDRED ELIZABETH ZARUBA 12:55 PM J 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner SQUARE dAle If Under 24 H OSC or 1 Year HOSDIA MORE 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F 212-36-1292 67 Feb. Director Maryland Usual Residence of Decedent the Maryland 10a. State 10h Count 10c City Town or Location 10d. Inside City Limits 28e-f show in than "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 TylYes 2 □ No Director Md. n/a Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1418 Jackson Street 21230 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give <sup>4</sup> Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be fited within 72 hours after Health and Mental Hygiene. 1 ☐ Never Married 2 💢 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Housewife Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Harry Peacock Agnes Marian Hesse ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 Department of Health a Importent: If Item 27 Is 1418 Jackson Street, Baltimore, Md. 21230 Thomas J. Zaruba (Husband) other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 DBurial 2 Cremation 3 Removal from State ò 4 ☐Donation 5 ☐ Other (Specify) Glen Haven Memorial Pk.03/02/04 Glen Burnie injury 22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A 21. Signature of Funeral Service License 130 E. Fort ave. Baltimore, Md. 23a. P.r.1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death inediate Cause (Final isease or condition resulting in death) Physician Duno (or as a consequence of): /Medical Examiner leFT lung elect Asis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed emolhorAx Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4□Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DREAST 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 X No 1 ☐ Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Vinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 2 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 24 hours after death.

96 Funeral Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 and manner stated To the 29b. Signature and title of ceptilier 29c. License number 29d. Date signed (Month, Day, Year) D0055034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIA SQUARE HUSPITAL (FATER BATTIMORE, MA DEDACOURS R CONAWAY 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar MAR 0 3 2004

-	•		1 - For State Registrar	State of Maryl		artment of He rtificate of D			ne no.2004	06680	
	Physici /Medi		1. Decedent's Name (First, Middle, L	ALUSHE,	ALS			2. Date of Death Month	Day 7 Year You	3. Time of Death	
)	Examir		4a. Fecility Name (If not institution, g	ive street and number)		4b. City, Town, or L	ocation of Death		4c. County of Death		
			Continuum Care 5. Social Security Number 6.	Sex 7. Age (In y	rs. last birthday)		kesville	8. Date of Birth	Carro		
	Funeral Director		220-075891	1₽M 2□F 94	Yrs.	Months Days	Hours Min.	Month, Day, Ye	1909 Mar	place (State or Foreign ntry) y I and	
	and and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits	
	Many -f she	to	Maryland Carro	011	Syk	esville				1 XYes 2 No	
	h the	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	ntry?	
	23a c		7309 Second <i>F</i>	lve.		217	84		U.S.A.		
21215-0036	72 hours atter death with the Maryland neturel', or items 23a or 28e-f show distal Exampler must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	panic Origin? (Spec Mexican, Puerto F Specify:	ofy Yes or No- lican, etc.)	14. Race - Ameri Black, White, Specify: Wh		
20	72 hours "neturel", dical Exa	ted	15. Decedent's (Specify only highest of	Education	16a. Dece	dent's Usual Occupati- kind of work done dur DO NOT use retired)	on ring most of warkin	166	. Kind of Business/Ir	,	
2	c _ 9	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired) rmer/labor		ag	riculture		
2	e tiled withi Il Hygiene. other then		17. Father's Name (First, Middle, La.	rt)	1 1 4			(First, Middle, Maid		e roads	
Maryland		To Be	Irvin W. Brash	•		, '		e Gess Al			
μŽ	E DE E	ř	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street and				Code)	
	nd 2 Ilth a 27 Is		Shirley B. Brown	/stepdaughter	1005	Pinch Val	ley Rd.	Westmi	nster, MD	21158	
Baltimore,	jes 1 and of Healt if item 2 or other		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3	Removal from State		natory or other place)			. Location - City or T	own, State	
Ë	nit. Pag artment ortent: i injury c		* 4 □ Donation 5 □ Other (Spec	ify) F		ek Cemeter		2004 nr	. New Win	dsor, MD	
Ball	permit. Pages: Department of the Importent: if ite any injury or of the terms of th		21. Signot the of Funeral Service Lic	I. Har Eler	10	2. Name and Address 310 Church	Hai	rtzler Fu ew Windso	neral Hom or, MD 217	e 76	
	Physician /Medical Examiner	Iner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as a con	sequence of):	, _	Λ	LOBALLAN AISE	E HILE	Approximate Interval Between Onset and Death	
68760,	ificate be executed g physician and as the burial-transit	edicai	edicai Examiner	Cades Chisease of injury that initiated events resulting in death) Last	c	sequence of):					
P.O. Box	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year	
	w requires that been signed t should be det	þ	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause given	in Part I.		co use contribute to t 2⊠No 3 ☐ Prot	ne cause of death?	
Vital Records,	The ate h page	Completed						24a. Was an autopsy performed 1 Yes 2 1	prior to co death?	psy findings available mpletion of cause of 2 No	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor	26. Place of Death				
of	Phys	To :	1 Yes 2 No	28a. Date of Injury	2 ER/Outpatien 28b. Time of	I SU DOA		e 5 ☐ Residence 3d. Describe how in	6 □Other (Specif	y)	
ion	nding F ath. r: After e funer	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day Year	r) Injury		s 2 🗆 No		,		
Division	Hospitel or Attending 24 hours after death. Funerel Director: After tely tilled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		at home, farm, str ecity)	eet, factory, office	25	Bf. Location (Street City or Town, St	and Number or Rura ate)	I Route Number,	
_	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely tilled in by the	edicai C	(Check only 2 Medical Exa	thysician: To the best of my aminer: On the basis of examand manner stated.	ination and/or inv	estigation, in my opin	ion, death occurred	at the time, date a	and place, and due to	the cause(s)	
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier			29c. License n	number	29d. i	Date signed (Month,	Day, Year)	
	· N		1/ Welses	Amendine	1	1)40	390	F	BOATY	13,2004	
	MA		30. Name and address of person who	completed cause of death (	Item 23a) (Type,	Print) . 1- +325	Dwina	Mus	Mn	411)	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1	Anteniling of death (1) 23 CAO SSN 32. Registar's Si 7 2004	gnature	hoests)					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2 Date of Deeth Bolanowski **Physician** 7125pm Mallon Februa /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner General Hospita Corner Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day, Year
Nov. 15, 1 5. Social Security Number 7. Age (In yrş. last birthday) Birthplace (State or Foreign Country) **Funeral** 1)X M 2□ F 6 218-09-0734 T917 Director Ohio Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Funeral Directo Carrol1 Maryland Mt. Airy 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 16350 Camalo Dr. 21771 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Detes: WW II 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Metallurgist 12th Armco Stainless Steel 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Joseph Bolanowski Katherine Servatka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Claire Hetrick (Executor) 2934 Brookwood Rd. Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 2/6/2004 Hampstead, MD 22. Name and Address of Facility Burrier-Queen Funeral Directors, P.A. 21. Signature of Funeral Service L/ce 1212 West Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Medicai Certification: To Be Compieted by Physiclan/Medical Examiner be detached for usa as the burial-transit Attending Physician: The law requiras that tha death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 Unknown 1 ☐ Yee 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an eutopsy performed? Aftar this certificate has 20 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 3□ DOA 2 ER/Outpatient To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: Attar this completely filled in by tha funeral is 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 □ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29d. Date signed (Month. Dev. Year) 29b. Signature and title of certifier 29c. License number 30. Name end address of person who completed cause of death (Hem 23e) (Type, Print) 00 0 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State

**DHMH 16 Rev 6/95** 

Registrar

FEB 1 2 2004

		For State Registrar	State of Mary	land / D	epartmen Certificat	t of H e of I	lealth a Death		Re	g. No.	04	06682
Dhuaiais	4	1. Decedent's Name (First, Middle, Last)		10	. C.		-		<ol><li>Date of Death Month</li></ol>	Day	Year	3. Time of Death
Physicia /Medic	al		nosa	Dr3:			7~-		Februsy	11	2007	G. 30 F M
Examin		4a. Fecility Name (If not institution, give s			4b. City,		Location of		_ ′	4c. County		: A
				nter			If Under 2		a. D. H. of Diah		SLLO	
Funeral Director		5. Social Security Number 6. Sex 1XI Security Number 1XI Usual Residence of Decedent	M 2 F	yrs. last birtl	Months	1 Year Days	Hours	Min.	8. Date of Birth (Month, Day July 30	<sup>Year</sup> 1924	9. Birthp Coun	lace (State or Foreign htry)
and w	-	10a. State 10b. County	100	c. City, Town	or Location						1	0d. Inside City Limits
f ehc	ō	MD Carrol	1	Wes	stminste	er					į	1 ☐ Yes 2 📆 No
28a	Director	10e. Street and Number			10f. Zip		<u> </u>		10	g. Citizen of V	Vhal Coun	itry?
3a or		225 Frock Drive				2.	1157			USA		
within 72 hours after death with the Maryland ene. Than 'natural', or items 23a or 28a-f ehow the Medical Examiner must be notified at	Funeral	11. Marital Status	2. Was Decedent Ever Armed Forces?	in U.S.	13. Was Dece	dent of H	lispanic Orig	in? (Spec	cify Yes or No- Rican, etc.)		e - Americ	
after or Ite		1 ☐ Never Married 2 ☐ Married	1X Yes 2 □ No		1 Tes, spe		Specify:	, 1 4010 1	noan, etc.,	Specify		
ral', c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		10 103	200	Spoony.			Speciny	· Wh	ite
72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a.	Decedent's Usu (Give kind of wo life. DO NOT u	al Occup	ation during most	of workin	ig i	6b. Kind of Bu	siness/Ind	dustry
ithin 36.	id I	Elementary/Secondary (0-12)	College (1-4or 5+)		iiie. DO NOT ii Purchas:					Rockv	<b>1</b> 1	
led w lygien her ti		12 17. Father's Name (First, Middle, Last)			rur Crias.	uig i		r's Name	(First, Middle, N			
be fi	Be	William Theodore	Bradfield						Potts		,	
1 Mer nark	우			10h	Mailing Addross	Stroot			Route Number,	City or Town	State Zin	Code
12 sh h and 7 ls n traun		19a. Informant's Name/Relationship (Ty, Marjorie Bradfield			25 Froc				inster,		L157	0000)
1 and tealt	1 3	20a. Method of Disposition		0b. Place of	Disposition (Na	me of	T			loc. Location -		own, State
uges in it of it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	Carro	y, crematory or o	other place + i Ot	n. The	2/1	1/2004	Hampst	ead.	MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  By any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>		Carro.	-							
Deparement of the popular in the pop		21. Signatura Gervine Constitution of the Cons	4		Pritts	Fu	neral"	'Home	and Ch. Westm	apel, l	.A.	21157
Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to (or as a co	nsequence o	Preum			cardiac or	r respiratory arre	st,	4	Approximate Interval Between Onset and Death  H Day S
be executed sician and burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co									
	dical											
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death	3 □Ectopic p 5 □ Other (s <sub>j</sub>		y				te of delive	ery Day Year
that that	by Pł	Part II. Dther significant conditions con	tributing to death but no	ot resulting in	the underlying	cause giv	ren in Part I.		23e. Did tob	acco use con	ribute to th	he cause of death?
n sign		C	erebral	Inf	arct				1 ☐ Ye	s 2 No	3 Prob	pably 4 □Unknown
w require been signature	Completed								24a. Was a		Were auto	psy findings available
The lav	ш								autops	ned?	death?	mpletion of cause of 2 No
ificati or, pa	CO	25. Was case referred to medical					26 Place	of Death	(Check only on	44110	103	2010
Physician: this certific	0	overninos?	Iospital: 1 Inpatient	2 ER/Ou	tpatient 3 De	OA Ott	200		ne 5 Reside		er (Specif	v)
ding Phy h. After this funeral o	1	27. Manner of Death	28a. Date of Injury (Month, Day Ye			28c. Injui Wo			8d. Describe ho			
a fun	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day 16	100	njury M		Yes 2 ☐ f	No				
al or Attences after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	At home, fa	rm, street, factor	y, office		2	28f. Location (St. City or Town		er or Rura	al Route Number,
To the Hospital or within 24 hours affe To the Funeral Dir completely filled in	Medical (	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of m ner: On the basis of exa and manner stated	amination and	i, death occurred d/or investigation	at the ti	me, date an opinion, deal	d place, a th occurre	and due to the ca ed at the time, da	ruse(s) and ma ate and place,	anner as st and due to	tated. the cause(s)
Го th within Го th	Me	29b. Signature and title of certifier	A -	0			se number			9d. Date signe		
Δ.		1	mo Apr	MO		Do	202599	143	F	-elans	ryll	1, 2004
MZ		30. Name and address of prison who co		(Item 23a) (	(Type, Print)	ive.	Suit	2 30	07 We	stmins	رسمه	1, 2004 MD 21157
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature								

ORIGINAL

DHMH 17 Rev 1/2001

Registra

2004

			For State Registrar	State of M	laryland / De	epartment Certificate			lental Hy	giene Reg. N2 0 0	L	06684
			Decedent's Name (First, Middle, La	ist)					2. Date of De	aath		3. Time of Death
	Physici /Medic		EDITH ADAMSON AR	MACOST ER	NEST				FEBRUA	RY 15, 20	004	10:20 AM
	Examin		4a. Fecility Name (If not institution, give GOLDEN AGE GUEST		7)		Town, or Loca ESVILL		-	4c. County of CARRO		
	Funeral Director		5. Social Security Number 212–12–9684 6. S	Sex 1□M XXF 7.A	ge (In yrs. last birth 84 Yr	Months	1 Year If Un Days Ho	nder 24 Hrs. urs Min.	8. Date of Bi (Month, D. AUGUST	27, 1919		lace (State or Foreign fox) RYLAND
	and *		Usuel Residence of Decedent  10a, State 10b, County		10c. City, Town	or Location					11	0d. Inside City Limits
	daryli f sho	ŏ		OT T	WESTMI							1 □ Yes 2 □ No
	1 the 1	Directo	MARYLAND CARF  10e. Street and Number	(011)	WESTPH	10f. Zip	Code			10g. Citizen of Wh	at Coun	
	h with	al D	1321 OLD WESTMIN	STER PIKE			21157			UNITED S	STAT	ES
	ems ?	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S.	13. Was Decede	ent of Hispani fy Cuban, Me	c Origin? (Spe	cify Yes or No	o- 14. Race -	America White, 6	
9	s afte	by Fu	1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give X	] No	1 ☐ Yes 2		ecify:	, , , ,	Specify:		
3	tural	ed p	15. Decedent's E	Year or Dates		ecedent's Usual	l Occupation			16b. Kind of Busi	ness/Ind	lustry
215-0036	within 72 hours after death with the Marylan jiene. rithan "natural", or Items 23a or 28e-f show It e Medical Examiner is not be notified at	plet	(Specify only highest gri Elementary/Secondary (0-12)		(9	Give kind of world fe. DO NOT use	k done during e retired)	most of worki	ng			•
N	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28e-f show int, Ite Madical Examinational be molified at	Completed				HOME	MAKER			DOME		C
/land	d la b	To Be	17. Father's Name (First, Middle, Last GEORGE ARM	ACOST				Nother's Name EDITH N		, Maiden Sumame) WN		
, Mar,	12 than		19a. Informant's Name/Relationship ( KELLY A. GREEN/L							er, City or Town, St STMINSTER		
e G			20a. Method of Disposition 1 🗆 Burial 2 🏡 remation 3	Removal from State	20b. Place of D cemetery,	isposition (Nam crematory or ot	e of her place)	1	ate	20c. Location - Ci	ty or To	wn, State
Ē	mit. Pages partment of l cortent: If Its Injury or o		`4 ☐ Donation 5 ☐ Other (Special	(y)	CARROLL	CREMAT		2/16/		HAMPSTEA	AD, 1	MARYLAND
Baitimore,	permit. Pages Department of I Importent: If Ite any Injury or of		21. Signature of Funeral Service Lice	Eloche	KLI VILLE	191 WIL	LIS ST	REET,	WESMI	E, P.A. INSTER, M	1D	21157
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each	ed the death. Dono	enter the mode	of dying, suc	h as cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. PRI	May Dye	uature &	Jewente	a				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of)	0	20 - 20				-	> 1 YR
Į		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	l (10) Usacul s a consequence of)	lon Di	July					1 40
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C								
Ď,	e exec ian an ırial-tr	Exa	resulting in death) Last	Due to (or as a consequence of):								
2/PU	ficate be execute physician and is the burial-trans	dical	•	d								
0	leath certific attending p I for use as I	/Med	IF FEMALE:	23c. If yes, outcom	e of pregnancy					201.0		4-4-4-4
C. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	by Physician/Me	23b. Was decedent pregnant in the past 12 moorths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth	2 ☐ Fetal death at time of death	3 ☐ Ectopic pre 5 ☐ Other (spe				23d. Date of Month		ry Day Year
Ţ.	that the ed by detac	/ Ph	Part II. Other significent conditions	contributing to death	but not resulting in the	ie underlying ca	use given in P	Part I.	23e. Did t	obacco use contribu	ute to the	a cause of death?
rds	w requires that been signed t should be deta								10	Yes 2□No 3	☐ Proba	ably 4 Honknown
Hecord	m on on	Completed			-					psy prio	ith?	sy findings available apletion of cause of
VITai	₩ C	BeC	25. Was case referred to medical				26. F	Place of Death	(Check only of		Yes 2	ZLET NO
o	> .∞ 0	ToE	examiner? 1 ☐ Yes 2 ☐ ¥6	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Outp	itient 3 DOA	Other: 4	Nursing Hon	ne 5⊡Resi	dence 6 Other	(Specify,	)
	ttending Ph death. :tor: After th : the funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b. Tim ay Year) Inju		lc. Injury at Work?		8d. Describe	how injury occurred		
DIVISION	death death ctor: /	cat	2 Accident investigatio 3 Suicide 6 Could not b	e 200 Diago of Ir	njury - At home, farm	M street factors	1 Tes		28f Location (	Street and Number	or Rural	Route Number
2	el or At s after d al Direct ed in by	Certification;	4 ☐ Homicide determined	building, e	tc. (Specify)	, street, lactory,	omos		City or To	wn, State)	0, 7,0,2,	riodie ridinoei,
	To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After t completely filled in by the funera	Medical (	29a. Certifier 1 Certifying Pl (Check only one) 2 Medicel Exer	nysicien: To the bes miner: On the basis and manner s	of examination and/o	eath occurred a ir investigation, i	t the time, dat in my opinion,	e and place, a death occurre	nd due to the	cause(s) and mann date and place, and	er as sta due to	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifler			29c.	License numb	ber		29d. Date signed (A	Month, D	Day, Year)
	WSZ		tateet Tune	AUD			D 5020	6		2/16/2	004	
	10		30. Name and address of person who ATRICK TURNES	completed cause of	death (Item 23a) (Ty	21 DA	ELD	ERSBUR	6 MD	21784		
	Sta Registr	_	31. Date filed (Month, Day, Year) FEB 1 7	72/	frar's Signature	beer						
						-						

			1 - State of Maryland / Department	urtment of Health and Me tificate of Death	ntal Hygien	71111	06685
ī		u	Decedent's Name (First, Middle, Last)		. Date of Death		3. Time of Death
	Physicia /Medic		Edith Franklin		Month D	ay O Year	1105 AM
Je	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Deat	h
			Westminster Musing And Rehab Center	Westminster		Car	
	Funeral Director		5. Social Security Number  215-36-8181  6. Sex 7  1 M 2 M F 76 Yrs.	Months Dave Hours Min	Date of Birth (Month, Day, Yea Ine 5, 192	7 9. Birt	hplace (State or Foreign untry) ryland
	pu .		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	action			10d. Inside City Limits
	faryla sho	ō					1 ☐ Yes 2 🗡 No
	28e-1	Director	Maryland Carroll New Wi	ndsor 10f. Zip Code	10a. C	itizen of What Co	
	death with the Maryland ims 23a or 28e-f show	I Di	3190 Sams Creek Road	21776	-	SA	
	death ms 2	Funeral	11 Marital Status 12, Was Decedent Ever in U.S. 13, V	Vas Decedent of Hispanic Origin? (Specif	y Yes or No-	14. Race - Ame	
0000	rs after i', or ite	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖔 No	f Yes, specify Cuban, Mexican, Puèrto Ric □ Yes 2 <sup>™</sup> No <i>Specify:</i>	can, etc.)	Black, White Specify: Wh	
3	2 hou		15. Decedent's Education 16a. Deced	ent's Usual Occupation	16b.	Kind of Business/	Industry
2 2	vithin 73	Completed	life. D	kind of work done during most of working OO NOT use retired) Wife		airy	
7	Hygie Hygie ther t	CO	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	First, Middle, Maide	n Sumame)	
and	ld be ental ked o	To Be	Chester Thomas Williams	Dora Eliz			
ary	shou and M s mar umat	-		g Address (Street and Number or Rural F	Route Number, City	or Town, State, Z	lip Code)
Ž	and 2 salth a n 27 is	-			stminster	, Md. 21	158
Поге	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other treumatic event. The Maritical Examinat must be multiput at once.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)		,2004 Un	Location - City or i	
Dall	permit. Departmimporte any inju		1	Name and Address of Facility Hartz			
i			23a. Part1. Enter the disease, or complications that caused the death. Do not enter	O Church St. New War the mode of dying, such as cardiac or re		d. 21//6	Approximate
	Physician		shock, or heart failure. List only one cause on each line.			8	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Metas Tatic  Due to (or as a consequence of):	rion Cancer			Months
	Examiner		Sequentially list conditions, b.				
	p ts	lner	if any, leading to immediate cause Enter Underhin Cause (Disease or injury			3	
_	cate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last  C.  Due to (or as a consequence of):		<del></del>		
9/00	sician buria	dicalE					
000		edic	<u> </u>				
ŏ	th certifi ending r use as	an/M	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 3□	Ectopic pregnancy		23d. Date of deli	
	w requires that the death certif been signed by the attending should be detached for use a	Physician/Me	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  1 □ Ves 2 □ No 9 □ Unknown	Other (specify)		Month	Day Year
	s that ned by deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
2	quires on sign uld be				1 ☐ Yes 2	2 ≤ 0 3 ☐ Pro	obabiy 4 🗆 Unknown
Recor	The law requires that the ate has been signed by th page 2 should be detache	ompleted			24a. Was an autopsy performed?	24b. Were aut prior to c death?	topsy findings available ompletion of cause of
VII	ificate or, pa	မ Co	25. Was case referred to medical	26. Place of Death (C	1 Yes 25N	o 1 🗆 Yes	2 No
-	ysicie is cert direct	0 8	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient	Other L		6 □Other (Spec	ify)
0	ng Ph ter thi	T :uc	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		d. Describe how inju		,,
VISION	endir eath. or: Af the fu	catle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
	of or Att	ertification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office 28f	Location (Street a City or Town, Star		rai Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death of the death of t	occurred at the time, date and place, and estigation, in my opinion, death occurred	due to the cause(: at the time, date ar	s) and manner as ad place, and due	stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	29c. License number	29d. Di	ate signed (Month	, Day, Year)
1	· KV		With the MO	00058137		2/11/04	í –
	Mag		30. Name and address of person who completed cause of death (Item 23a) (Type, F Willow Kus 1295 Stoner Ave St	Print)	ter Mr	2110	-7
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	July Mezioning	1.10	2113	,
	Registr	ar	FEB 1 7 2004 Steen St.	boarde			

State of Maryland / Department of Health and Mental Hygien 200 i. 06686 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Margaret Falardeau 1150 PM **Physician** ebruary 22 2004 /Medical 4c. County of Deeth 4h City Town or Location of Death 4e. Fecility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown 9. Birthplece (State or Foreign Country) New Jersey If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 24, 1908 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 🖾 F 216-74-4358 95 Yrs. Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Washington Hagerstown Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21740 14120 William Talcott Lane Funeral 14. Rece - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: White þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) mit. Pages 1 and 2 should be filt partment of Health and Mental Hy portant: If item 27 Is marked oth y injury or other traumatic aven James Senior Lillian Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1374 Park Place Westville, N.J. 08093 Dorothy Lenkowski/Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page:
Department of
Important: If if
any injury or 1 ■ Burial 2 Cremation 3 Removal from State Beautiful View Cemetery 2/26/04 Washington Co. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. Martin 17225 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, onges Immediate Cause (Final disease or condition resulting in death) live **Physician** /Medical Due to (or as a consequence of) Examiner oil Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical phys use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ed by the atter in the past 12 months?
1 Yes 2 XNo 5 ☐ Other (specify) 4 Pregnant at time of death P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate ha 2 1 No 1 ☐ Yes 2 No 1 TYAS Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient ٩ 3 DOA his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1. Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident within 24 hours after death

To the Funeral Diractor:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00060396 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Opal Court SHED MUR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 03 Registrar

Registrar DHMH 17 Rev 1/2001

State

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33a Part

**ORIGINAL** 

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30. Name and address of person who completed cause of d-ath (Item 23a) (Type, Print)

DRIVE, SUI

32. Registrar's Signature

OSCEN

FEB 1 7 2004

7600 31. Date filed (Month, Day, Year) 00047625

OWSON, MP

2/16/04

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 14, 2004 **Physician** SHIRLEY RUTH GREEN 04:16 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WESTMINSTER CARROLL CARROLL HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Day, Year 1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1□ M 2√2 F MARYLAND 213-30-7506 70 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23a or 28a-f show the Medical Examinating by notified at 1 ☐ Yes 2 ➡No Director MARYLAND CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1908 STONE ROAD 21158 UNITED STATES Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1□ Yes 2□ No Specify: WHITE δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withi nent of Health and Mental Hygiene. int: if item 27 is marked other then HOMEMAKER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EDNA MAE MYERS WILLIAM FRANKLIN STAIR, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THEODORE H. GREEN/HUSBAND 1908 STONE RD, WESTMINSTER, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XX urial 2 Cremation 3 Removal from State injury or permit. Page Department of Important: If any injury or once. PLEASANT VALLEY CEMETERY 2/18/04 WESTMINSTER, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): sate has been signed by the attending physicien page 2 should be detached for use as the burial P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2. No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No certificate 1 Yes or Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Medical Certification: To 2 SR/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending after death. 1 Yes 2 No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funerel Direct completely filled in by 4 Homicide Fo the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 16, 2004 10051294 WIT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Herbert V. Hend Muncheste I. MO 20173M anchester 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB Registrar

			For State Registrar	State of M	aryland / Der		of Health of Death		•	giene <sub>2</sub> (	004	06689
	Physici /Medic		1. Decedent's Name (First, Middle, ROS and C	harbe A	nthony	Glo-	roso		2. Date of De Month	Day 12	2004	3. Time of Death 3 - 30 PM
	Examin		4a. Facility Name (If not institution,		0		own, or Location				ty of Death	1.3
	Formula		1716 Doe Drive		je (In yrs. last birthda	y) If Under 1		er 24 Hrs.	8. Date of Bir (Month, Da		9. Birthp	L L lace (State or Foreign try)
	Funeral Director		212-12-1461	1 <b>X</b> M 2 □ F	95 Yrs.	Months	Days Hours	Min.	Jan 13	1909	Coun	MD_
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					1	0d. Inside City Limits
20	Maryl I sho	tor	MD Car	roll	Fink	sburg						1 ☐ Yes 21 No
GLORISO	death with the Maryland ma 23a or 28a-f show Emast be notified at	Funeral Director	10e. Street and Number		-1	10f. Zip				10g. Citizen o		itry?
GI(	sath w	eral	1716 Doe Drive	12. Was Decedent	Ever in U.S. 13	3 Was Decede	21048	rigin? (Spe	cify Yes or No		ISA ace - Americ	an Indian,
ANTHONY 215-0036	after or ite	by	11. Marital Status  1 □ Never Married 2 □ Marrie  \$€ Widowed 4 □ Divorced	Armed Forces?		If Yes, speci	ent of Hispanic C fy Cuban, Mexica XNo Specify		Rican, etc.)	Spec	ack, White,	
NT:	"naturel",	leted	15. Decedent's (Specify only highest	Education grade completed)	(Gi	cedent's Usual ve kind of work . DO NOT use	k done durina mo	ost of workin	ng	16b. Kind of	Business/Ind	dustry
. (4	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		perator			Ba	rber	
CHARLES Maryland 21	be filed withing tal Hygiene. d other than event, Ire M	Be C	17. Father's Name (First, Middle, L.	ast)			•	her's Name	(First, Middle	Maiden Suma	ame)	
CHARLES aryland		To E	Angelo Glorioso						ta Gep			
Mar	2 4 7 1		19a. Informant's Name/Relationshi			-	(Street and Num					Code)
	s 1 and f Health item 27 other to		Anita Morsberger 20a. Method of Disposition		20b. Place of Dis	position (Nam	Drive	2/16.		10 210 20c. Location		wn, State
ROSARIO	8 ° = 5		1 ☑ Burial 2 ☐ Cremation :  4 ☐ Donation 5 ☐ Other (Sp.		Meadow			-		West	minste	er, MD
ROS Salt	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service	icensee			Address of Fac Funera					
	40340		23a. Park. Enter the disease, or o shock, or heart failure. List of	complications that cause	d the death. Do not o	412 Warnter the mode	ashingto of dying, such a	n Roa as cardiac o	d West	minste	r, MD	21157 Approximate
	Physician		shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each I	ine.		100	30	Den	Caro		Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of	1		A	0	1		years
	Examiner	10	Sequentially list conditions,	b. — Due to (or as	consequence of):	rary	W	llery		sease		0
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			,				
760,	ite be executed lysician and he burial-transit		resulting in death) Last		a consequence of):							
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Division of Vital Records, P.O. Box 68	To the Hospital or Attanding Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death	3 □Ectopic pre 5 □ Other (spe					Date of deliver	ny Day Year
ds, P	w requires that been signed b should be deta	þ	Part II. Other significent condition	contributing to death I	but not resulting in the	brull	ause given in Par	t I.				ne cause of death? ably 4 Munknown
io Se	aw rec Is bee 2 shou	Completed	Sick	Simus	Sync	brown	e		24a. Was		. Were auto	psy findings available appletion of cause of
E A	The law cate has page 2	Com	acid	) peptic	disea	e e			perfo	2 No	death?	2 No
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:			Other		(Check only			daughtys
ō	Physer this eral di	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inj	ury 28b. Time ay Year) 28b. Time		Bc. Injury at Work?			dence 6 🔼 C		Residence
ion	uttanding death. ctor: Aft / the fun	atio	1 XNatural 5 Pending 2 Accident investig	ation	11/01	м	1 Yes 2					
ivis	after de Direct	Certification:	3 Suicide 6 Could n 4 Homicide determine	280. Place of in	ijury - At home, farm, tc. <i>(Sp</i> ec <i>ify)</i>	street, factory	, office	1	28f. Location ( City or To		nber or Rura	l Route Number,
L	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Ce	29a. Certifier 1 Tertifying (Check only one)	Physicien: To the best examiner: On the basis of and manner s	of examination and/or	eath occurred a investigation.	at the time, date a in my opinion, de	and place, a	and due to the ed at the time,	cause(s) and i	manner as s e, and due to	ated. the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of certifier	TX10 0	- 0-	29c	. License numbe	701		29d. Date sign	ned Month,	Day, Year)
	MA		•	Volvali	المساح		1) (	2013	>	2	-1131	04
	of N		30. Name and address of person v	vho completed cause of KALARIA	0.10	ashun	aten +	teigh	も. し	Jestin	isln	Md 21157
	St	ate	31. Date filed (Month, Day, Year)	3 2004 S	trar's Signature		,					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 10 14 06690 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 8 3. Time of Death Month **Physician** 4:25A M Februa John Charles Hartman 2004 /Medical 4a. Fecility Name (If not institution, give street and number) County of Death **Examiner** 4b. City, Town, or Location of Death Coutons VIII rwet les nar HIMOre 5. Social Security Number 7. Age (In yrs. last birthday, Birthplece (State or Foreign Country) **Funeral** Days Hours Min. 12XM 2□F Yrs 93 1910 Director Maryland 216-09-4472 Usuat Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28e-f show the Medical Examinar must be notified at Director 1 ☐ Yes 2 No Maryland | Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Sams Creek Road 21157 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Completed by f Yes, Give Year or Dates: Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Railway Express years Agent Peges 1 and 2 should be filed v tment of Health and Mental Hygie 1 ant: If item 27 is marked other t jury or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Charles S. Hartman Charlotte S. Scoggins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois M. Winship daughter 504 Locksley Road Towson, MD 21157 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Department of Important: If any injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery Feb. 14, 2004 Baltimore, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Directors, PA 1212 W. Old Liberty Road Winfield, MD 21784 permit. Pert. Enter the disease, or complications that care ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on perch line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician neumonia Iwea /Medical resulting in death) Due to (or as a consequence of): **Examiner** hu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, ician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🖫 Yes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 Yes 2 1No in by the funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier 29b. Signature and title of certifier 29c. License number WIL of person who completed cause of death (Item 23a) (Type, Print) 10 30. Name and addres Maid 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygien 2004 06691 1- State Registrar AMEND #8, 17 PER FH CCHD 2/25/04 DECERTIFICATE Of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** February 15, 2004 Hopkins 1:55 P Mary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Marys 24292 River Drive Chaptico | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 0/19/30 | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 T F 73 220-28-7376 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r then "natural", or Items 23a or 28a-f shov the Medical Examinativest be notified at 1 Yes 2 No Chaptico Director Maryland St. Marys 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24292 River Drive 20621 **USA** 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after d il Hygiene, othar then "natural", or Item 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: Black ð 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hygient Important: if item 27 is marked other the any injury or other traumatic event, Image. Dietician NIH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOSEPH WILLIAM CHASE William <del>Joseph</del> Chase-Mary Olivia Edelen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph A. Chase/Brother 24311 River Drive Chaptico, Maryland 20621 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State St. Marys Ch Cem 2/23/04 Bryantown, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Offer Odesoa MO1323 Adams Funeral Home P.A. Aquasco, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer Pnysician 000 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, loading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant ned by the atten e detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 2 No 1 Tes Attanding Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification; 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death.
To the Funerel Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 20622 St. Marys Medica Center 37767 Market Dr. anwala, m. D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 2004 06692 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 19 **Physician** February 0040 A M Francis A. Iampieri /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Cecil SunBridge Care Center Elkton 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 89 Vrs Delaware Director 221-01-0790 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 l Price Drive United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: ۾ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic evant, Ite Made once. Elementary/Secondary (0-12) College (1-4or 5+) Tailor Garment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francis Iampieri Rosaria DiAnistasio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany Eileen McClay/Daughter 29 East Moyer Drive, Bear, Delaware 19701 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🖺 Other (Specify) Enterment Cathedral Cemetery 23, 2004 Wilmington, Delaware 21. Signature of Funeral Service Licensee .22. Name and Address of Facility. Hicks Home for Funerals, P.A. ) orold 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alherosclerotic Heart Physician unknown /Medical Due to (or as a consequence of): Examiner typerlension Sequentially list conditions, a any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Organic 1 Yes 2 No 3 Probably 4 Wunknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manger of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident s after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospital t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tiple of certifier 29d. Date signed (Month, Day, Year) achderSus 2.26,2004. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3B Elkan MD21921 SACHDEN MD 118 North St Suite 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 03 2004 Registrar

			1- For State of Maryland / Dep	partment of Health and Nertificate of Death		ene g. No. <b>20</b> 04 06693
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	Physici /Medio		Linda Murphy Johnston		February	Day Year 7:30 A M
}	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			2675 Walston Rd.	Mt. Airy		Carroll_
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birthplace (State or Foreign Country)
	Director		212-44-3401		Oct 31,	1945 Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or 1	ocation		10d. Inside City Limits
	Mary	ö	Maryland Carroll Mt. Airy			1 ☐ Yes 2 ☐ No
	15e	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	3a or	ā	2675 Walston Rd.	21771		United States
	death	Jera	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
Maryland 21215-0036	2 should be flied within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "neturel", or Items 23a or 28e-f show eumatic event, I'te Madical Examiner rust be notified at	by Funeral	Armed Forces?  1 ☐ Never Married 2 ☒ Married   1 ☐ Yes 2 ☒ No   1 ☐ Yes, Give   Year or Dates:	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Black, White, etc.  Specify: White
2	72 hc	Completed		edent's Usual Occupation e kind of work done during most of work	ring 1	6b. Kind of Business/Industry
2	ithin Ban Mac	ם	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	ang .	
2	ed wi	ပ္ပ	- Jeno	ol Teacher		alt. County Public Sch
	be fit d out	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	aiden Sumame)
$\frac{8}{2}$	ould Men Merke Marke	မ	Woolford Murphy	Hazel		
<u>a</u>	2 sh and is m reum			ling Address (Street and Number or Run		
ď	l and lealth m 27 her t			Walston Rd. Mt. A	-	
Ö	ges it of the life or ot		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, cri	ematory or other place)		Oc. Location - City or Town, State
Ē	tmen tmen tant:			Cremation $\frac{2}{18/2}$	004 Ha	ampstead, MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other treumatic evonce.		Bi Bi	22. Name and Address of Facility urrier—Queen Funer; 212 W. Old Liberty	al Direct	ore PA
8760,	physician and purial-transit sthe burial-transit	dical Examiner	23a. Fart. Enter the disease, or complications that caused the deeth. Do not explore shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	coma-metas		Interval Batween Onset and Death
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
S,	es tha igned be det	ð	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?
o D	requir een s nould	ted	- Frimary pulmonary hyp	ertension	1 Tes	2 No 3 Probably 4 Unknown
Il Records,		Completed	/ 1 / / /		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Vital	ician Sertifii ector	Be	25. Was case referred to medical examiner?		h (Check only one)	
	this ald	Ţ.	1   Tes 2   No 1   Inpatient 2   ER/Outpatie		•	ce 6 Other (Specify)
<u></u>	Jing I	ion	1 Natural 5 Pending (Month, Day Year) Injury	Work?	28d. Describe how	injury occurred
<u> </u>	ttendeath death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, s	M 1 Yes 2 No	28f Location /Stre	et and Number or Rural Route Number.
Division of	tel or A	Certification;	4 Homicide determined 288. Place of Injury - Artificity, farm, s	neet, factory, office	City or Town,	State)
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cau red at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
)		2	29b. Signature Inditite of continue MD	29c. License number D00 46 0 9	6 290	I. Date signed (Month, Day, Year)
	MIC		30. Name and address of person who completed cause of death (Item 23a) (Type Hope McInture MO 1502	S. Main St., M	T. Airy	m021771
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Societi s		
			FFD 1 CUUT COMPANY			

State of Maryland / Department of Health and Mental Hygiene 06694 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 14, Beatrice Johnson February 2004 2:55 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Days Social Security Number 6. Sax Birthplace (State or Foreign Country) **Funeral** 1□M **2**77F Yrs. Director June 12,1920 215-54-5377 83 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **WOHe** Examiner must be notified at 1X Yes 2 No Director Maryland Charles White Plains the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 20695 10370 Faith Hope Place USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ? Is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ignatius Brawner Ethel Bealle permit. Pages 1 and 2 shoul Department of Health and Mimportent; If Item 27 1e marl any injury or other traumations. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Coates/Daughter 10370 Faith Hope Pl White Plains, Maryland 20695 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State \$t. Josephs Ch Cem 1 

Burial 2 □ Cremation 3 □ Removal from State 2/20/04 Pomfret, Maryland \* 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dodessa affer MO1323 Adams Funeral Home P.A. Aquasco, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septi **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Completed by Physiclan/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No the 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ★Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 1 Yes 2 XNo 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 Hapatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Diractor: After that in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af To the Funeral D completely filled in To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28035 2-14-04 9135 Pis cotoway Rd. #210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOLIA, MID. BASIRMOHMAD 31. Date filed (Month, Day, Year) 32. Ranstrar's Signature, State Registrar

Beatrice

			State  For State Registrar	e of Maryland	/ Depa	artment rtificate	of Heal	th and Math	ental Hyg	iene 2 (	004	06695
	Physicia	an	Decedent's Name (First, Middle, Last)	1					2. Date of Deal Month	Day	Year	3. Time of Death
	/Medic		Michaelene J Fic			4h City 3	Town, or Loca		February		2004 nty of Death	8:55P M
	Examin	er	4a. Facility Name (If not institution, give street an Kline Hospice House	a number)		4b. City,		Airy			rederi	ick
			5. Social Security Number 6. Sex	7. Age (In yrs. las	it birthday)	If Under	1 Year If U	•	8. Date of Birth			place (State or Foreign
	Funeral Director		216-76-0116 1DM 2D		Yrs.	Months	Days Ho	urs Min.	8. Date of Birth (Month, Day)	1957	Mary	(land
			Usual Residence of Decedent			1						
	how is		10a. State 10b. County	10c. City,	Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2 📉No
	sa-f s	cto	Maryland Frederick				Airy					
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	er de Item	in.	Arme	Decadent Ever in U.S. ed Forces? Yes 2 🔯 No	13.	if Yes, spec	ify Cuban, Me	exican, Puerto F	cify Yes or No- Rican, etc.)		lack, White,	
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7	d with	Completed	12	2	home	emaker		l desig				lorist
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<u>8</u>	Ment Ment arked	၉	Michael Fiore						nary Ste			
Mar	2 sh and is m		19a. Informant's Name/Relationship (Type, Print	"		-	(Street and N Iville		A Route Number			Code)
≤ 1)	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Madical Examination at the notified at		Thomas Loven/ husband 20a, Method of Disposition	20b. Pla					Mt. Airy	20c. Location		own. State
5	in it of h		1 Burial 2 ☐ Cremation 3 ☐ Removal			natory or of		2/10		ibert		
Dallillo	it. Partmer trtmer ortant njury		* 4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee	1 31.								, MD
מ	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		athana () X	La Dler	/   1	1802	Libert	v Rd.	tzler Fu Libert	unera I	Home	1762
			23a. Part1. Enter the disease, or complications	that caused the death.							,	Approximate Interval Between
	Dharisian		shock, or heart failure. List only one cause Immediate Cause (Final		Jak	\	1	.01	244 8-			Onset and Death
	Physician /Medical		disease or condition resulting in death)	Won - Ho	ince of):	- 14	7	-1100	<i>70</i> -C			Lyears
	Examiner		Sequentially list conditions b. ——					1				
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	requires that the death certilicate be executed been signed by the attending physician and should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events c	ue to (or as a conseque	nno of):							
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žog	atten atten I for u	cian	in the past 12 months?	Live birth 2 ☐ Fetal of Pregnant at time of dea		∃Ectopic pro ∃ Other (sp.					Month	Day Year
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	sician: The law certificate has t irector, page 2 s	E							perfor	med? 21X No	death? 1 ☐ Yes	mpletion of cause of
Vital	Physician: ' r this certifica ral director, p	Be C	25. Was case referred to medical examiner?					Place of Death	(Check only or	ne)		
<u></u>	hysic his ce Il dire	2	1 ☐ Yes 2 No Hospital:	1 Inpatient 2 LE		nt 3□ DO	1		ne 5 Resid			y) Hospice
Ē	ing P	on:	1 Natural 5 Pending	Date of Injury (Month, Day Year)	28b. Time o Injury	и 2 М	8c. Injury at Work? 1 ☐ Yes	i	28d. Describe h	ow injury occ	urrea	
<u>s</u>	tend leath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At horr	ao farm et				28f Location (S	treet and Nur	mber or Bur	al Route Number,
DIVISION	or Al after o Direct in by	Certification;	4 Homicide determined 28e.	building, etc. (Specify)	ie, iaini, st	reet, factory	, once		City or Tow	n, State)	11001 01 1101	
_	spital	S C	29a. Certifier 1 Certifying Physician: (Check only 2 Medical Examiner: On	To the best of my know	ledge, deat	h occurred	at the time, da	ate and place, a	and due to the c	ause(s) and	manner as s	tated.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Examiner: On one)	the basis of examination I manner stated.	on and/or in	vestigation,	, in my opinior	n, death occurre	ed at the time, o	ate and place	e, and due to	o the cause(s)
	To the vithin To the comp	Ĕ	29b. Signature and title of certifier			290	. License nun	/ 8 6		9d. Date sigi	ned (Month,	Day, Year)
	WITH		16hr	-, "	(su		ソーフ	100			9, 20	
	3		30. Name and address of person who completed Kanan Hudwalimp				hann	Drive	Fro	dans	k.m	n 21702
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		0 00	· OVYYV	DIIVE	( ,		-1111	7 0(11
	Regist		FEB 1 1 2004	Bleeve	K	Some	1 s					
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 06696 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 6, 2004 **Physician** DAVID MEARS 6:00  $\mathbf{P}^{\mathsf{M}}$ /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **OUEEN ANNE'S** 17 MARINERS WAY, UNIT #4 STEVENSVILLE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, )
DEC. 20, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□ F 79 Yrs. Director 1924 MARYLAND 220-12-3360 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show item 27 is marked other than "naturel", or items 23s or 28e-f shov other treumatic event, the Modical Examinations to condition at **QUEEN ANNE'S** STEVENSVILLE 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 17 MARINERS WAY, UNIT #4 21666 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 XYes 2 No If Yes, Give Year or Dates: 1943-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify: Specify: ģ 3 ☐ Widowed 4 ☑ Divorced 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES **MANUFACTURING** 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy importent: If item 27 is marked other any injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DAVID MEARS LOTTIE D. KRAMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2556 RIVER TREE CIRCLE, SANFORD, FL DAVID MEARS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY 01/11/2004 STEVENSVILE, MD 21. Signature of Fundral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one oduse ions that caused the death. Do not enter the mode of dying Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit death certificate be executed P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, á 3- Probably 1 ☐ Yes 2 ☐ No 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? Yes 2 No this certificate has 1 ☐ Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, F. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number death (Item 23a) 31. Date filed (Month, 32. Reg State Registrar

			1 - For State Registrar	State of Mary	rland / Depa	artment of H	lealth and	Mental Hyg	_	
			Hegistrar     Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·		tinoate or i	Jean	2. Date of Deat		3. Time of Death
	Physici		Thomas Ridgley	Myers				Februa	ry 10,	Year 2004 10:15 pM
	/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, Town, or	Location of Dea		4c. County	
			1658 St. Paul Stre	eet		Hamps	tead		C	arroll
T	Funeral		5. Social Security Number 6. Sex	M 000	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth (Month_Day,	Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		75 Yrs.			Aug 5,	1928	Maryland
	land www.		10a. State 10b. County	10	c. City, Town or Lo					10d. Inside City Limits
	Mary -f sh	ţō	Maryland Carroll				Hampstea	ad		1 ☐ Yes 2√€ No
	h the	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Country?
	death with the Maryland rms 23a or 28a-f show rmust be notified at	aiD	1658 St. Paul Stre	et			21074		US.	A
	r dea	Funeral	11. Marital Status	<ol><li>Was Decedent Ever Armed Forces?</li></ol>	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (	Specify Yes or No- to Rican, etc.)		e - American Indian, k, White, etc.
9	hours atter tural', or ite	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give	1945- 1949	1 ☐ Yes 21 No	Specify:		Specify	WHITE
2-003p	tural	edt	15. Decedent's Educ	Year or Dates:	16a Decer	dent's Usual Occupa	ation		16b Kind of Bu	usiness/Industry
2	within 72 ene. than *nai	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	during most of wo	orking		y
7	d with	E O	12	College (1-40/34)	I	Produce C	lerk		Groce	ery Store
	be filed within 72 hours after death with the Marylan ital Hygiene. A contract of other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	Be (	17. Father's Name (First, Middle, Last)					me (First, Middle, M	Maiden Sumam	e)
yland	should to nd Ment marked umatic e	2	Ridgley Myers				Heler	Lee		
Mar	2 sh and is m		19a. Informant's Name/Relationship (Typ			-		ural Route Number,		
_	iit. Pages 1 and 2 should erment of Health and Mer ortant: If Item 27 is marke injury or other traumatic		Laura Robertson, d					Westmins		City or Town, State
Baltimore,	Pages ment of I tant: If its jury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	emoval from State		sition (Name of matory or other place	100/3	2/2004		stead, MD
	permit. Page Deportment Important: If any injury or once.		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fineral Service License	e 2 MO		Cremation  Name and Addres		Eline Fun		
ñ	Dep mp any		+ Strues/1	Valle	30			t, Hampst		
			23a. Part1. Enfer the disease, or complice shock, or heart failure. List only one	eations that caused the	death. Do not ent					Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	tausa y each mie.	tia.					Onset and Death
	/Medical		resulting in death)	Due to lor as a co		ces de la				1 2 Galy)
	Examiner	L	Sequentially list conditions, b.	End Son	ge Co	6D				10 gears
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter the design of printing.	Due to (or as a co	insequence of):					
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
Ç Ç	uires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit	caiE	d							
S	certificat nding phy use as the	_								
žog	th cer endin	ician/Med	23b. was decedent pregnant	c. If yes, outcome of p		Ectopic pregnancy				e of delivery
	e death of the attenued for u	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time 9☐ Unknown		Other (specify)			Mon	nth Day Year
r Ö	hat the d by the letache	Physi	Part II. Other significant conditions cont	ributing to death but no	at reculting in the un	adorhina couco auc	on in Port I	23a Did tah	anno uso contri	ibute to the cause of death?
ďs,	requires that een signed b hould be deta	d by	artis, other signment sonditions com	induing to could but it	or resulting at the di	identyling cause give	minit route.			3 ☐ Probably 4 ☐ Unknown
Ö	required .	ete						24a. Was ar		Voro outanov findings qualishle
Hecord	e la has je 2	ompleted						autopsy perform	y pi ned? d	Vere autopsy findings available rior to completion of cause of eath?
VItal	iclan: Th certificate rector, pag	e C	25. Was case referred to medical				26 Place of De	1  Yes 2 ath (Check only one	/	Yes 2 No
	Physician: this certitic	OB	examiner?	ospital:	2 ER/Outpatien	t 3 DOA Othe		dome 5 Reside		er (Specify)
0	ding Phys h. Atter this tuneral dir	J: L	27. Manner of Death 1	28a. Date of Injury (Month, Day Ye.	ar) 28b. Time of Injury	28c. Injury Work	at	28d. Describe ho		
VISION	eath. or: A	catio	2 Accident investigation			M 1 🗆 Y	/es 2 □ No			
Ë	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)	eet, factory, office		28f. Location (Str City or Town	eet and Numbe , State)	er or Rural Route Number,
	pital ours a eral [		29a. Certifier 1 Certifying Physi	cien: To the best of m	v knowledge death	Conversed at the time	a data and place	and due to the co		
	24 hc 24 hc e Fun etely	edical	(Check only 2 Medical Examinations)	er: On the basis of exa and manner stated.	imination and/or inv	estigation, in my op	inion, death occ	urred at the time, da	ite and place, a	nd due to the cause(s)
	To the Hospital or Attending Pl within 24 hours atter death. To the Funeral Director: Atter to completely titled in by the tunera	Me	29b. Signature and title of certifier	110		29c. License	number	29	d. Date signed	(Month, Day, Year)
			1 6 40 X00 Km			D3	6112	2	2-12-6	04
	WILA		30. Name and address of person who con	npleted cause of death	(Item 23a) (Type,					
	STIVA		D. Alexander Roch			voods Tra	il, Hamp	stead, MI	21074	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's						
	ricgisti	प्रा	FFB 1 2 7	2004 Files.	10 . M.	how . V .				

State of Maryland / Department of Health and Mental Hygiene State AMEND ITEM #23c PER PHY G829 3/03/0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death FEBRUARY **Physician** 6. 2004 1:45 AM James Stanley Mumma /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Center Saint Joseph Medical Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1⊠M 2□ F 60 04/06/1943 MD**Director** 213-40-4509 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show ther must be notified at 1 ☐Yes 2 ☐ No Hagerstown MD Washington Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 USA 11227 Lakeside Drive death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: the Medical Exer 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Security 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fit timent of Health and Mental H tant: If Item 27 is marked ott jury or other traumatic even Be Julia E. Dunn William S. Mumma 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11227 Lakeside Drive, Hagerstown, MD 21740 Teresa A. Mumma / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. Cedar Lawn Mem. Gdns. 02/08/2004 Hagerstown, MD \* 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service License 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition CARDIOGENIC SHOCK **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner BIVENTRICULAR FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed ASCENDING AORTIC ANEURYSM WITH AORTIC INSUFFICIENCY 3 MONTHS physician an is the burial-tr resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical as attending p IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4 Pregnant at time of death □Yes 2□No the 9 Unknown 9 Unknown ģ det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2♥ No 24a. Was an has page 2 certificate 2 🔽 1 ☐ Yes No or Attending Physician: ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 2 1 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ΠNα this 28a. Die f Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Magner of D Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the f Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 THomicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 38570 s of person who completed cause of death (Item 23a) (Type, Print) Hà EDWARD M. D. . 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State EB 09 Registrar

Physician   MayDeen   Hodson   Morris   February   23 , 2004   234!   MayDeen   Hodson   Morris   February   23 , 2004   234!   Aa. Facility Name (If not institution, give street and number)   4a. Facility Name (If not institution, give street and number)   4a. Facility Name (If not institution, give street and number)   4b. City, Town, or Location of Death   Harford   4c. Country of Death   Harford   Harford   Harford   Harford   Harford   Harford   Harford   Sex   Social Security Number   5. Social Security Number   6. Sex   6	
4a. Facility Name (If not institution, give street and number)  Harford Memorial Hospital  Funeral Director  14a. Facility Name (If not institution, give street and number)  Harford Memorial Hospital  15. Social Security Number  15. Social Security Numbe	
4a. Facility Name (If not institution, give street and number)  Harford Memorial Hospital  Havre de Grace  Harford  S. Social Security Number  5. Social Security Number  6. Sex  1 Months  7. Age (In yrs. last birthday)  Year  9. Birthplace (State County)  Months  Days  Hours  Min. Months  Nov. 19, 1910  Missouri	or Foreign
Funeral Director  5. Social Security Number  6. Sex 1 Months Days  6. Sex 1 Months Days  Funder 1 Year If Under 24 Hrs.  6. Sex 1 Months Days  Funder 1 Year If Under 24 Hrs.  8. Date of Birth  (Month Day, Year)  Min.  10 V 19, 1910  9. Birthplace (State Country)  Missouri	or Foreign
Usual Residence of Decedent	or Foreign
Usual Residence of Decedent	
To all Theide	
MD Harford Bel Air    100. Street and Number   101. Zip Code   102. Citizen of What Country?	City Limits
10e. Street and Number  700 E. Heritage Ln.  11. Marital Status  1	s 2□No
700 E. Heritage Ln.  21014  U.S.A.  11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  1 Specify only highest grade completed)  15. Decedent's Education  (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  21014  U.S.A.  13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify:  White  16a. Decedent's Usual Occupation  (Give kind of work done during most of working life. Do NOT use retired)	
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Ma	
1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White  To be a second of the se	
White    Signature   College   Coll	
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry	
College (1-4or 5+)	
Teacher Education	
TO DEFEND 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)	
Homer Landing Hodson  Nellie Catherine Kline	
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Homer Harold Morris-son 204 Farm Road, Aberdeen, MD 21001	
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State	
Cometery, crematory or other place)  1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)  R. A. Ferris & Co., Inc.  West Chester, PA	
20a. Method of Disposition 1 Burial 2x Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A.	
A SOUTH PAIRE St., ADELDER, MI MINIS	
23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximately the mode of dying, such as cardiac or respiratory arrest, interval Exposes and the cause on each line.	etween
Immediate Cause (Final disease or condition resulting in death)  Amedical  Immediate Cause (Final disease or condition resulting in death)  a. Systemic Inflammatory Response About	
/Medical resulting in death)  Due to (or as a consequence of):  Syndrome	rek
Sequentially list conditions b.	-
[ A → A → B → B → C → C → C → C → C → C → C → C	
The part of the pa	Vana
- 1 0 0 0 - 10163 2 0100   A 11 = leavin	Year
O to the state of	
6 2 50 6	
Suspected Metastatic Disease  1 Yes 2 No 3 Probably 4	JOHAHOWH
O S S NO C KLAA TALLICO 240. Was an autopsy prior to completion of autopsy	s available cause of
performed? death?	
24a. Was an autopsy finding autopsy performed?    24b. Were autopsy finding autopsy performed?   1   Yes 2   No   Yes   No   No   Yes   No   Yes   No   No   Yes   No   Yes   No   No   Yes   No	-
Hospital: Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death  28a. Date of Injury  28b. Time of 28c. Injury at 28d. Describe how injury occurred	
27. Manner of Death  28a. Date of Injury  27. Manner of Death  27. Manner of Death  28b. Time of Injury  3 DOA  4 Nursing Home  4 Nursing Home  4 Nursing Home  5 Residence  6 Outlief (Specify)  27. Manner of Death  28b. Time of Injury  4 Nursing Home  28c. Injury at Work?  1   Yes 2   No	
Column   C	mber,
Dilliding, etc. (Specify)  City or Town, State)	
building, etc. (Specify)	/->
28a. Date of Injury   28b. Ime of Death   28b.	(S)
29a. Certifier (Check only one)	
Continued   Cont	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year Digital)  29d. Date signed (Month, Day, Year Digital)	2004
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year one)  30. Name and address of person who completes cause of death (Item 23a) (Type, Print)	2004
Mamy My no D19583 February 24	2004 evdeen

			Tor State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of H	lealth and I Death	Heg	2004	06700
	Physici /Medic		Decedent's Name (First, Middle, Last)     Charles	Ellsworth		Morgan		2. Date of Death Month February	Day Year 24,2004	3. Time of Death 2:09P M
	Examin		4a. Facility Name (If not institution, give st Frederick Memor 5. Social Security Number 6. Sex				Location of Death Derick		4c. County of Dear	rick
	Funeral Director		215-26-7862	M 2□F 74		Months Days	Hours Min.	Feb. 24	, 1930 N	thplace (State or Foreign ountry) Maryland
	e Maryland ta-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Freder	rick	, Town or Lo	ocation	Keymar			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28	Il Director	10e, Street and Number 12114 LeGore Bridg	ge Road		10f. Zip Code	2175		g. Citizen of What Co U.S.	
36	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show ta Madical Exeminat reast by inclified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: [	
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene.  Id other than "natural", or liems 23a or 28a-f show other than "natural", or liems 23a or 28a-f show avent, it a Madical Evaruinat result be neitified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done o DO NOT use retired ICK Drivel	during most of wor f)	rking	Sand & G	Andustry Favel Compan
Maryland 2	should be filed withir had Mental Hygiene. marked other then imatic event, IDEM	To Be C	17. Father's Name (First, Middle, Last) Lewis Franklin Mo	organ		72	18. Mother's Nar	ne <i>(First, Middle, Ma</i> e Margeret	iden Sumame)	
Mary	d 2 sho th and h 7 is ma trauma		19a. Informant's Name/Relationship (Type Rosemary E. Morgan)					oral Route Number, o pad, Keyma	•	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.	. 9	20a. Method of Disposition  1 Burial 2 X remation 3 Re  4 Donation 5 Other (Specify)	20b. Pl	lace of Dispo	osition (Name of matory or other place	(e)		c. Location - City or	
Balti	permit. Departm Importa any inju		21. Signal re of Funeral Service Licenses  21. Signal re of Funeral Service Licenses  22. Signal re of Funeral Service Licenses  23. Part 1. Enter the disease, or complice	farl MOO	021	Name and Address Keeney &	ss of Facility and Basfo	ord Funera	1. Home	
8760,	Physician /Medical Examiner    The burial-transit	dical Examiner	shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Chonic obs Due to (or as a consequence of the conse	ructive ail under sono of):	ie Pulmi re				Interval Between Onset and Death  1 D Years  4 days  1 day
.O. Box 68	ne death certift the attending hed for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
s, P	quires that the signed by all be detacted	ed by Ph	Part II. Other significant conditions cont Pancreatitis	· ·		, ,	en in Part I.	23e. Did toba	<b>V</b> /	o the cause of death? robably 4 DUnknown
Division of Vital Record	The law requir sate has been si page 2 should	Completed	Hyponatremie	2				24a. Was an autopsy performe 1 □ Yes 2	prior to death?	utopsy findings available completion of cause of s 2 🕅 No
Vita	rsician s certific director	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 No	ospital: 1 1 Inpatient 2 🗍 I	ER/Outpatier	nt 3 DOA Oth	ar	ath <i>(Check only one)</i> fome 5 Residen	ce 6 MOther (Spe	ecify)
ion of	nding Phy ith. : After this e funeral c	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	f 28c. Injur Wor		28d. Describe how		, any,
Divisi	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of triury - At ho building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	Hospit 24 hour Funera etely fills	edical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicat Examin	ician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the cau arred at the time, dat	se(s) and manner as and place, and due	s stated. e to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number	290	Date signed (Mont	th, Day, Year)
7	X		30. Name and address of person who cor	mpleted cause of death (Item	1 23a) (Type.	1)42 Print)	641	a d	-25-	04
	7		Stephen Lee MD. 31. Date filed (Month, Day, Year)	mpleted cause of death (Item 610 Solare 32 Registrar's Signal	ture Col	urt, Fr	ederic	K Ma	reland	21/103
	Sta Regist	ate rar	MAR 03	2004	H	Page 8: 8	-			

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

004

U.S.A.

14. Bace - American Indian

Black, White, etc.

Specify: WHITE

Month

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 No

02-26-200

Year

6:32 PM

Birthplece (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2 □ No

2004

2. Date of Death

25

Feb.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 0 3 2004

32. Registrar's Signature

For State Registrar

**Physician** 

1. Decedent's Name (First, Middle, Last)

State Registrar DHMH 17 Rev 1/2001

Vidyasagar Anmangandla, MD PO Box 282, Charlotte Hall, MD 20622

D

26064

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				State of Ivia	i yiaiia 7	Certifica			incinal in	Reg. N.20	04 0	06702
	Physici	an	1. Decedent's Name (First, Middle, Las	•					2. Dete of D	eath Day	Year	3. Time of Death
4	/Media	al	Joan Catherir  4a Fecility Name (If not institution, give					th City Town o	Febru	ary T.	2004 y	7:45AM
F	Examir	er	Charlest					Cator	- 11	0	y or Death	9724
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last bi	rthday) If Uni	der 1 Year	If Under 24 Hr Hours Mir	s. 8. Date of Bi		9. Birthplac	e (State or Foreign
	Director		210-12-0044	□M 2只F	83	Yrs.	Days	riouis Mair	Dec 31	, 1920	Maryla	and
	land		Usuel Residence of Decedent  10a. State  10b. County		10c. City, Tow	m or Location					10d.	Inside City Limits
	Mery Ff sh	ţo	Maryland Baltimor	re			Cá	atonsvil	le			1 ☐ Yes 2 ☑ No
	within 72 hours efter deeth with the Meryland ene. than "naturel", or iteme 23a or 28e-f show he Medical Examiner must be notified at	Completed by Funeral Director	10e. Street end Number			10f.	Zip Code			10g. Citizen of	What Country	?
	eth w	rai	713 Maiden Choice					21228			USA	
_	iter de	-un-	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces?		13. Was De	cedent of H becify Cuba	ispanic Origin? ( ın, Mexican, Pue	Specify Yes or Norto Rican, etc.)	D- 14. Ra	ce - American ick, White, etc.	
21215-0020	urs et	by	3 ☑ Widowed 4 □ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes	2 <b>√</b> №	Specify:		Specif	t⁄r whi	ite
5-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a	. Decedent's U	sual Occup	ation during most of we	orkina	16b. Kind of B	Business/Indust	try
121	within ne. than "	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	)	House		during most of wo		Own	Home	
<b>d</b> 2	Hygie Ther Ther	ပိ	17. Father's Neme (First, Middle, Last)			110050	WITE	18. Mother's Na	me (First, Middle	, Maiden Sumai	me)	
ian	should be filed value with the second	To Be	Unknown					Lilly	Mae Har	dy	,	
Maryiand	2 shot end N is ma		19a. Informant's Name/Relationship (T)	ype, Print)					lural Route Numb			
	end ;		David Hayden, sor	1					Box 68,			
Baitimore,	semit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Merylan Deperment of Heelth end Mentel Hyglene. mportant: if item 27 is marked other than "naturel", or itema 23a or 28e-f show my injury or other treumatic event, the Medical Examinar must be notified at 2008.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State		f Disposition (Nature)			02/11	20c. Location		
itin	nit. Peg artment ortent: li injury o		4 ☐ Donation ☐ Tother (Specify)  21. Signature of Funeral Service Licens			oll Cre		ONS ss of Facility	2004	namp: uneral l	stead,	עוע
Ba	pemit. P Depertmoner Importer eny injur		1 Sterred	™0072	11/2 0				t, Hamps			
		$\dashv$	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	lications thet caused th	ne death. Do	not enter the m	ode of dyin	g, such as cardia	c or respiratory a	rrest,	Ap	proximate
	hysician		SHOOK, OF HEART RAILURE. LIST OTHY O	ne cause on each line.	- 1	\					On	erval Between iset and Death
	/Medical Examiner		immediate Cause (Final disease or condition resulting in death)	a	tro	ske						week
		-	Tooling it down,	De	ue to (or es a	consequence o	f):				1	*
	ficete be executed physicien end is the buriel-trensit	Examiner	Sequentially list conditions	b	ue to (or es a	consequence o	n·					
ó,	e exek	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events		(	1,5	,				1	
68760,	rificete be executed ng physicien end es the bunel-trensit	dica	that initieted events resulting in death) Last	Du	e to (or as e	consequence of	):			<del></del>		
9 X C	= 50	Physician/Medical	<b>L</b> ,	d								
. Box	The lew requires thet the deeth cer is hes been signed by the ettendin page 2 should be detached for use	Cla	Part II. Other significant conditions cor	ntributing to death but	not resulting i	the underlying	cause give	en in Part I.	23h Did	tobacco use co	otribute to the	cause of death?
P.0	res thet the de signed by the e i be detached i	Phy S	escente care				g			Yes 2□ No	3 Probabi	111000000000000000000000000000000000000
	signed d be d	۾							S		177	
Š	v requir been si should	eted								an autopsy omed?	availab	autopsy findings ble prior to etion of cause
Records,	The lew sete hes page 2 :	Completed							***		of deat	
Vital		0	25. Was case referred to medical					26. Place of De	ath (Check only o	Yes 2 No	1 1 76	es 2 No
of <	8 w 0	10 B	examiner? 1 ☐ Yes 2 ☐ Ho		2□ ER/Ou	tpatient 3 1	Othe Othe	er.	Home 5 ☐ Resi	The second	er (Specify)	
	fing Phy h. After thi funerel		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. 1	lime of njury	28c. Injury Work		28d. Describe	how injury occur	red	
Division	Attending it deeth. Sctor: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home fa	m street facts		res 2 □ No	28f Location (	Street and Numb	var or Queal Qo	uta Number
οį	efter defer de Directed in by	Certification:	4  Homicide determined	building, etc. (	Specify)	iii, 311661, 1200	ry, onice		City or To		er or Huarrio	ute rumber,
			29a. Certifier 1 Certifying Phys	sician: To the best of n	ny knowledge	, death occurre	d at the tim	e, date and place	e, and due to the	cause(s) and ma	anner as stated	f.
	the H hin 24 the Fi	Medical	one)	and manner state	d.				aneu at the time,			
4	A IN CO. O.		29b. Signature and title of certifier	LT.	Λ.		9c. License		9 1	29d. Date signe		01
	NST		30. Name end eddress of person who	moleted cause of dead	th (Item 23a)	Type Print)	D	7100		rebru	rary	1,2004
	6		Phillio S	tone	7111	Youde	M C	hoice	Lane	Balt	1 M DE	9,2004 MDZ1228
	Stat Registra	-	31. Dete filed (Month, Day, Vear) FFR 1 9	32. Registrates	Signature	1. 0				/	1	/

				artment of Health and Mer <i>rtificate of Death</i>	ntal Hygiene	06703
	Physici	an	Decedent's Name (First, Middle, Last)		Date of Death Month Day Yea	3. Time of Death
	/Media	cal	Catherine Lucille  4a. Facility Name (If not institution, give street and number)	Proctor Fe	Month 2003	
	Examir	ier	1712 Addison Road South	Forestville	4c. County of De Prince Ge	eorges
H	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday, 81 Yrs.	If Under 1 Year   If Under 24 Hrs.   8.   Months   Days   Hours   Min.   October 1	Date of Birth (Month, Day, Year) XET 15, 1922 Mar	irthplace (State or Foreign Country) Yland
	show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	a-fsh iifie J	ctor	Maryland Prince Georges Forestvil	le		1 Yes 2 □ No
	or 28	Directo	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	Country?
	eath v	Funeral	1712 Addison Road South  11. Marital Status 12. Was Decedent Ever in U.S. 13.	20747 Was Decedent of Hispanic Origin? (Specify	Ves or No- 14. Race - An	nerican Indian
980	be filed within 72 hours after death with the Maryland hat Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examinat must be indiffed at	þ	Armed Forces?  1 Never Married 2 Married I Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes XXNo Specify:	an, etc.) Black, Wh	ite, etc.
5-0	72 hc	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Busines	s/Industry
21215-0036	e filed within at Hygiene. I other than "vent, the Max	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Homem		Domestic	:
nd 2	be filed ntal Hygie of other	Be C	17. Father's Name (First, Middle, Last)	· ·	rst, Middle, Maiden Surname)	
Maryland	should be ind Mentat marked o umatic eve	2		ctor Mary		npson
Mai	2 2 2 2	1		ng Address <i>(Street and Number or Rural Ro</i> Addison Rd South For		
re,			20a. Method of Disposition 20b. Place of Dispo	osition (Name of Date	20c. Location - City of	
imo	Pages ment of ant: If it		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	rs Ch Cem   2/21/04	Waldorf, Ma	ryland
Baltimore,	permit, Page Department of Important: If any injury or once		011-4	2. Name and Address of Facility  dams Funeral Home P.	A. Aquasco, Mary	land
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	spiratory arrest,	Approximate Interval Between Onset and Death	
'n	Pnysician /Medical	a j	resulting in death)	ont		7 dogs
	Examiner		Due to (or as a consequence of):	a Host Deace		You
	70 H	ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	- November 1		10
	be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last   C			
8760,	cate be executed obysician and the burial-transit	dlcal E	d			
9		0	IF FEMALE:			
Вох	leath certifi attending p	Physician/M	23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy	23d. Date of de	elivery Day Year
o.	at the de by the a tached	nyslc	1	Other (specify)		
s, P	es that igned b be deta	by Pl	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use contribute	o the cause of death?
ord	w require been si should t	ted	CrV.H		1 Yes 2 No 3 F	robably 4 Unknown
Division of Vital Records,	The lar ate has page 2	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Ye	utopsy findings available completion of cause of
Vita	Physician: 1 this certificat ral director, p	o Be	25. Was case referred to medical examiner?	26. Place of Death Ch		
ō	g Phys er this eral di	<b> -</b>	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 28d.	5 X residence 6 ☐ Other (Specific Properties of the Specific Properties of	ecify)
ion	Attending ir death. ector: Afte by the fune	atlo	1 ☐Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Divis	al or Attenos s after deat il Director: ed in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, stream building, etc. (Specify)		Location (Street and Number or R City or Town, State)	ural Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, deatly not the basis of examination and/or in and manner stated.	n occurred at the time, date and place, and overstigation, in my opinion, death occurred at	due to the cause(s) and manner a t the time, date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	
			Thomas The laborer	0101923	Fab. 16, 7	004
1	83		30. Name and address of person who completed cause of death (Item 23a) (Type			
	Sta		31. Date filed (Month Day, Year) 0 2004 32. Refistrar's Signature	Sand a		
	Registr	ar	I ED W COUT			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** WILLIAM W. PROCTOR 12:55 PM February 13, 2004 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charlotte Hall Veterans Home St Marys Charlotte Hall If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 19 1933 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours **X** M 2 □ F Washington, DC 70 Yrs Director 579-50-3304 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or Items 23s or 28s-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 ☑ No St Marys Charlotte Hall Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 29449 Charlotte Hall Road 20622 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Y Yes 2 No fr Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes X No White Specify: Completed by 3 Widowed Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 2121 Elementary/Secondary (0-12) College (1-4or 5+) Laborer Furniture Industry s 1 and 2 should be filed w f Health and Mental Hygier Item 27 ie marked other th Unknown 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be Unknown Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) : If Item 27 i 20637 PO Box 670 Hughesville, MD Susan J. McMillin (PRD) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages 1 Department of P 1 🔀 Bupa | 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem 2-26-04 Cheltenham, MD 4 □ Denation 5 □ Other (Specify) Important: 22. Name and Address of Facility Eberwein Funeral Services 21. Signature of Juneral Service Licensee M00173 4433 White Pls. La. White Pls., MD 20695 Pa 11. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to or as a consequence of): Examiner Socially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran cular disease the attending physician Physician/Medical the as IF FEMALE: use a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year į in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death detached 9 Unknown o 9 Unknown ģ ۵ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes No certificate Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 No ŏ this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation completely filled in by the Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeral I 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier D45092 30. Name and address of person who Amply ted cause of death (Item 23a) (Type, Print) Prince Fedrick, MD 20678 110 Hospital 31. Date filed (Month, Day, Year) FEB 2 0 32. Ref State 2004 Registrar

			1 State of Maryla	nd / Depa	artment of F	lealth and Me Death	ental Hygie	2004	06705
	Physici	an	Decedent's Name (First, Middle, Last)     GLENN JOSEPH PRYOR				2. Date of Death Month	Day Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give street and number)		4	r Location of Death	000	4c. County of Death	
			Sacred Heart Hospit  5. Social Security Number 6. Sex 7. Age (In yr.	s. last birthday)	Cium k	T	B. Date of Birth	Allegai	
唐	Funeral Director		5. Social Security Number   6. Sex   7. Age (In yr. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	s. rasi birtinday) Yrs.	Months Days	Hours Min.	(Month, Day, Y	ear) Coui	place (State or Foreign ntry) YLAND
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. 0	City, Town or Lo	ocation				10d. Inside City Limits
	Maryl B-f ehc	tor	MARYLAND ALLEGANY	FROSTBUI	RG				1 ☐ Yes XXNo
	or 28	Funeral Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	ntry?
	eath v	eral	10118 PARKERSBURG ROAD, SW  11. Marital Status  12. Was Decedent Ever in	U.S. 13	Was Decedent of H		ify Yas or No-	U.S.	can Indian.
920	d within 72 hours after death with the Maryland jiene. I than "natural", or Items 23s or 28s-f ehow the Medical Evarul ar must be indiffied at	by	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ican, etc.)	Black, White,	
21215-0036	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occup	nation during most of working	16	b. Kind of Business/In	dustry
2121	within iene.	ошр	Elementary/Secondary (0-12) College (1-4or 5+)		NDUCTOR	<sup>2</sup> )		RAILROAI	)
nd	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		•	
Maryland	should be nd Mental nmarked umatic ev	P P	JOSEPH H. PRYOR  19a. Informant's Name/Relationship (Type, Print)	19b Maili	ng Address (Street			IELWRIGHT  ity or Town, State, Zip.	n Code)
	nd 2 state are trau		MILDRED PRYOR / WIFE	1				OSTBURG, N	
Baltimore,			1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	cemetery, crei	osition (Name of matory or other place			c. Location - City or To	
Em	t Pa rtmer rtant		4 □ Donation 5 □ Other (Specify)  21. Signatur of uneral Service Licensee		ERLAND CR 2. Name and Addre		24/04 CU	MBERLAND,	MD
Ba	Deporting any once		Man M Sowe	S	OWERS FUN	ERAL HOME,	P.A. FR		4D 21532
			Part I. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.  Immediate Cause (Final	1 4	ter the mode of dyin	ig, such as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a const	755	- new	VI Tan II	ne		2 weeks
	Examiner		Sequentially list conditions, b. Athero	sclerch	c Carel	io vascula	n dise	ise	2yens
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events c.	equence or):					
, 0	sate be executed oblysician and the burial-transit		resulting in death) Last Due to (or as a conse	equence of);					
68760,	physic ptysic s the b	dical	d						
Box (	death certifica attending ph of for use as the	an/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy	,		23d. Date of delive	
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?  1   Yes   2   No		Other (specify)			Month	Day Year
s, P.O.	res that the digned by the be detached	by Ph	Part II. Other significant conditions contributing to death but not re	esulting in the u	inderlying cause giv	en in Part I.	23e. Did tobac	co use contribute to the	he cause of death?
ord	w require been sig should b						1 🗆 Yes	2 No 3 Prob	pably 4 Dunknown
Vital Records,	0 5 0	ompleted					24a. Was an autopsy performed	prior to co	ppsy findings available impletion of cause of
Ital	ician: Th certificate rector, pag	e C	25. Was case referred to medical			26. Place of Death	1 Yes 2 Check only one)	(No 1 ☐ Yes	2 2 No
of V	Physician: this certific ral director,	To B		☐ ER/Outpatier		4   INDISING HOME		e 6 ⊡Other (Specif	у)
ono	ling After une	tlon:	27. Manner of Death  1 Natural 5 □ Pending (Month, Day Year)  5 □ Accident investigation	28b. Time o Injury	Wor	y at 28 k? Yes 2 ☐ No	3d. Describe how	injury occurred	
Division	al or Attending after death. I Director: After d in by the funer	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined 1 Suicide 1 Suicide 1 Suicide 28e. Place of Injury - At building, etc. (Spe	home, farm, sti			8f. Location (Stree City or Town, S	it and Number or Rura	al Route Number,
Ö	ospital or hours afte uneral Dir ly filled in I	1							
	To the Hospital or within 24 hours after To the Funeral Dit completely filled in	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my king the part of the basis of examination and manner stated.	nation and/or in	n occurred at the tin vestigation, in my o	ne, date and place, an pinion, death occurred	d at the time, date	e(s) and manner as s and place, and due to	the cause(s)
	To the To the comp	M	29b. Signature and title of certifier		29c. Licens	e number	29d.	Date signed (Month,	Day, Year)
	10		Worksocksthin MD  30. Name and address of person who completed cause of death (It	em 23a) (Type	Print)	073343	F	-eb 23, 2	404
	10		WONSOCK SHIN MD 4	8 Tur	n Ter	race !	nostbu	vg MD21	532
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 3 2004	nature	Books	7		-eb 23, 2 ug MD21	

State of Maryland / Department of Health and Mental Hygiener 06706 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:40 am Day Yeer **Physician** EVELYN M. RUMSEY EBRUGRY 11,2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore C

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Hospital of Baltimore rs. 8. Date of Birth (Month, Bay, Year)
JAN. 25, 1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ₩ F PENNSYLVANIA 163-24-8782 74 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-fahow 1 ☐ Yes 2√2 No Director PENNSYLVANIA **ADAMS** HANOVER the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 5617 HANOVER ROAD 17331 Completed by Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married  $K \iota \iota m s e \iota f + E \vee e$ . Baltimore, Maryland 21215-0036 ö 1 ☐ Yes Ž**O**XNo Specify: Specity: WHITE 3 ☐ Widowed 4 ☐ Divorced n res, Give Year or Dates: "naturel", 15. Decedent's Education (Specify only highest grade completed) of other than "natu 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than 8 HOMEMAKER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I THOMAS RICHARD GOUKER HELEN MARGARET KRICHTEN ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree 900. 140 CHEETAH DRIVE, HANOVER, PA DONALD E. RUMSEY/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 15 Burial 2 ☐ Cremation 3 🖫 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ANNUNCIATION CEMETERY 2/13/04 MCSHERRYSTOWN, PA 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A. 21. Signature of Funeral Service Lice Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final filorohisticcytome metastatic **Physician** 12 years resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ER/Outpatient 3 DOA this sid funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeret L To the Hospitet completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-00 February 11, 2004 MS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Ave. Mariya F. Darland, MD Sinai Kospital of Baltimore, MD 21215 Mariya Darland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 2 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year George Runyons, Jr. February P24 2004 2124 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Elkton Cecil If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Sociel Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Yrs. Director 65 229-40-3040 SEPT 3, 1938 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner mast be notified at 1 ☐ Yes 2 🖾 No Director Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Itams 23a 874 East Old Philadelphia Road by Funeral <u>United States</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: 3 Widowed 4 Divorced "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Automobile Elementary/Secondary (0-12) College (1-4or 5+) Executive Automotive 10 Manufacturing Attendant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 George Runyons Ida Keene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 874 East Old Philadel hia Road, Elkton, MD 21921 Ona Marie Runyons/Wife 20b. Place of Disposition (Name of cometery, crematory or other place)
North East Methodist 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ott February 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 28, 2004 Cemetery North East, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerdia Arrhy thomas /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Disco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): ng physician as the burial Completed by Physician/Medical attending use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months? Month Year 5 ☐ Other (specify) 4 Pregnant at time of death signed by the a d be detached f ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 35 No certificate 1 Yes or Attending Physician: completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2) No Medical Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 XNatural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. the 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0056327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) III West Hish Cychen 1 tel IND PA 1 . Suite 312 EIKton MM 21921 54 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 Registrar 200

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 State Registrar AMEND ITEM #24a PER PHY 0831 5/11/08/rt Amcate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANUARY 12, 2004 7:30 A<sup>M</sup> GORDON SEARING RONALD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner OUEEN ANNE'S STEVENSVILLE 205 BEACHSIDE DRIVE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Months Hours 1 XM 2□ F 150-26-9237 71 MAY 14, 1932 **NEW JERSEY** Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in then "naturel", or items 23a or 28a-f show the Medical Examiner must be rivilled at 1 ☐ Yes 2 🔽 No QUEEN ANNE'S STEVENSVILLE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21666 205 BEACHSIDE DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No 1952—
If Yes, Give Year or Dates: 1956 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specity: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) AVIATION MECHANIC 12 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked ANNA MARY GERMAN DANIEL REXFORD SEARING 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If item 27 is HELEN M. SEARING/WIFE 205 BEACHSIDE DRIVE, STEVENSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. STEVENSVILLE CEMETERY 01/15/2004 STEVENSVILLE, MD 4 ☐Donation 5 ☐ Other (Specify) FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 21. Signature of Face al Service Licensee m00982 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death metastatic cancer unknown primary Immediate Cause (Final -moute **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physicien Physiclan/Medlcal as the IF FEMALE use 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 | Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? ŏ 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown ል 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ syndrome be muelodus plastic 2 No 3 Probably 4 | Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has certificate 1 Yes 2 **XX**Vo To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 2 1 🗌 Yes this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After Injury 5 Pending investigation 1 Natural 2 ☐ Accident 1 Tyes 2 No within 24 hours after deatl To the Funerel Director: in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Qate signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHICLE E. COLONICU, WO 900 Bestgare Rd. Annapolis, Md. 21401

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2004

			1 - For Stata Registrar	State of M	laryland	d / Depa <i>Cei</i>	artment tificate	t of H	ealth a	and Me		giene Reg. No. 2	2004	06709
	Physicia	an	1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic			Smith				1000	1		Februai		, 2004	10:03 A M
	Examin	er	4a. Facility Name (If not institution, give 2915 Hempstead D		)				Location o				nce Ge	
	Comment		5. Social Security Number 6. Se	7. A	ge (In yrs. la	ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt	h		place (State or Foreign
	Funeral Director		219-48-5386 X	<b>X</b> M 2□F	55	Yrs.	Months	Days	Hours	Min.	June 10	, Year) 194	8 Ken	tucky
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation							10d. Inside City Limits
	shov	5						_					}	1 □ Yes 2X No
	the M	by Funeral Director	Maryland Prince G	eorges	Ţ Fτ.	Wash:	10f. Zip					10g. Citize	n of What Cou	intry?
	3a or	0	2915 Hempstead Dr	ive				2	0744				USA	
	death	nera	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S	S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spec	cify Yes or No Ricen, etc.)	- 14.	Race - Amer Black, White	
9	or Ite	Fu	1 Never Married 2 Married	1 🐧 Yes 2 🗆 If Yes, Give	] No		1 ☐ Yes 2		Specify:	.,	,,	1		ite
Ö	72 hours after death with the Maryland 'netural', or Items 23a or 28a-f show dical Exantinet must be routlied at	d b	3 ☐ Widowed 4 💆 Divorced	Year or Dates:	Viet		dent's Usua	LOccuo	ation			16h Kind	of Business/li	adustry
7	in 72 n "nel	piete	(Specify only highest gra	de com <i>pleted)</i>	(6.1)	(Give	kind of wor DO NOT us	k done d	<i>turing</i> most	t of workin	g	TOD. KING	or Dusinos <b>u</b> n	idastry
21215-0036	d with giene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Pain	ter					Pair	iting C	ompany
힏	al Hy al Hy d othe	ВеС	17. Father's Name (First, Middle, Last)	6							(First, Middle,			
yla	ould to	၉	Walter Leon Smith					(2)			e Chris			- 0.43
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "netural", or Items 23e or 28e-f show other treumatic event, the Medical Examiner must be rotified at	1	19a. Informant's Name/Relationship (1)				•				Route Number	-		
, e	1 and Healt tem 2		20a. Method of Disposition	313661	20b. PI	ace of Dispo	sition (Nam	ne of			ate Nu		tion - City or T	
<u>o</u>	ages ant of at: If if		1 XXBurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		³   Mar	<sub>'yland</sub> 'yland	Vetei	rans	"Cem	2-26-	-04	helte	nham,	MD
Baltimore,	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Funeral Service Licen		00053	22	Name and	Addres Fun	era l	Home		. D. O.O.O.		
_	2224		23a. Part1 Enter the disease, or com	olications that couse	ed the death	. Do not ent	er the mode				orf, N		04-015	Approximate
			shock, or heart failure. List only one cause on each line.  Interval between Onset and Death											
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. MESOTHELIOHA  Due to (or as a consequence of):											
	Examiner		Sequentially list conditions	b										
	ם ב	iner												
	ecute and I-trans	Examine	that initiated events c. resulting in death) Last Due to (or as a consequence of):											
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687	ficate g phys	edic		. d							-			1
Вох	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pr	egnancy				230	d. Date of deliv	•
	deat he attr	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant			Other (sp						Month	Day Year
P.0	law requires that the de as been signed by the a 2 should be detached	Phy	9 ☐ Unknown  Part II. Other significant conditions of		but not rock	ulting in the u	ndarking o	auco ana	an in Part I		23e Did to	obacco use	contribute to	the cause of death?
	ires tha signed d be de	þ	AS BESTOSIS	oninbuting to death	DOL HOL 1850	alling in the a	ndenying G	ause give	311 III 7 CATE 1.	•		res 2□!		
Š	w requires t been signe should be	Completed	707-2-10110	<del></del>							24a. Was	an is	24h Were aut	oney findings available
Rec	The law ate has page 2 :	ם									autop perfo	rmed/	death?	opsy findings available ompletion of cause of
Vital Records,	en: Th tificate tor, pa	င်	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes	2 No	1 🗆 Yes	2 □ No
Ξ	Physicien: rthis certifica ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat	tient 2 🗆 I	ER/Outpatier	nt 3 DO	A Othe	DF:		e 5 Resid		Other (Spec	ify)
اه د	ig Phi ter thi		27. Manner of Death	28a. Date of In	jury Jay Year)	28b. Time o	f 2	8c. Injury Work	at	2	8d. Describe h	now injury o	eccurred	
Sior	Attending in death.  ector: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	1			М		Yes 2□	_				
Division		27. Manner of Death  1										on (Street and Number or Rural Route Number, Town, State)		
	Hospite 4 hours Funerel ely fillec	edical C	29a. Certifier 1 Certifying Ph (Check only one)	niner: On the basis	n: To the best of my knowledge, death occurred at the time, date and pl On the basis of examination and/or investigation, in my opinion, death o and manner stated.				d place, au th occurre	ce, and due to the cause(s) and manner as stated curred at the time, date and place, and due to the		stated. to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifie				290		number			29d. Date s	igned (Month	Day, Year)
	. >- 0		> curgaraxa	are MD				-	01661	19		Febru	ary 18	2004
5	131551		30. Name and address of person who Corozone Soares,					ace.	Suit	e 104	l. Lamd			
	Sta Registi		31 Date filed (Month Day Year)	931	trar's Signat	ture			2010		,	3.019	20	
	3		, _ D		-									

-13/	3		1 - State Unpend Item#23a. Registrar	State of Mai 27,Per ME,G82	yland / Dep. 9 <b>,3/23/04eg</b>	artment of rtificate of	Health and I	Mental Hygi	ene 0 0	06710	)
	1. Decedent's Name (First, Middle, Last)							2. Date of Death		3. Time of Death	_
	Physic /Medi		Nunez	Luna	Valer	10		February	Day 2	Year 004   01:48 P.	VI
	Exami		4a. Fecility Name (If not institution, giv	,			or Location of Deat	h	4c. County o	f Death	
		N.	Frederick M				derick			derick	
9	Funeral Director		NONE	ØX. 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days				9. Birthplace (State or Foreig Country) Mexico	jn
	land ow		Usual Residence of Decedent  10a. State 10b. County	1	IOc. City, Town or Lo	ocation				10d. Inside City Limits	s
	Many a-f sh	to	Pa Fran	Vlin	Wayn	125 120				1 X Yes 2 □ No	0
	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wi	nat Country?	
	ath w	ral	6 East Ma			1-	7268		Mex	ico	
	ltems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of If Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- American Indian, , White, etc.	
336	be filed within 72 hours after tal Hygiene. d other than "natural", or Ite event, the Maritcal Evantine.	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 Yes 2□ No		111111111111111111111111111111111111111	Specify:	M misson	
9	2 hou	ted	15. Decedent's E		16a. Dece	dent's Usual Occu	pation	XICan	6b. Kind of Bus	iness/Industry	
21	ithin /	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	•	king			
121	led w lygien her th	S	6			Labor			Ste	el	_
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, Ite Medical Examinat must be notified at once.	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, Ma	aiden Sumame,	)	
Z	should ad Me mark matic	2	19a. Info III m's Name/Relationship (	Nunez Type Print) (SON	19b Mailie	na Address (Stree	t and Number or Bu	ral Route Number.	Una Town S	tate Zin Code)	_
	nd 2 saith ar 27 is		Elicon	Ivala Me	1 ! .	E. Ma	•			~	_
Baltimore,	s 1 a of Hea item othe		20a. Method of Disposition		20b. Place of Dispo cemetery, crer	sition (Name of	ocel	Date 20	c. L cation - C	ity or Town, State	1
in o	Page nent c int: If iny or		1 Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Specif		Panteon M			-1-2004	an Jose	La Chachada	
alt	permit. Departrimporta		21. Signature of Juneral Service Licer	ns A	22	. Name and Addre	ess of Facility		our's	ica, mexico	
<u> </u>	805 2 3		Alan C.7	users F.	st: Dugar	Funeral	Home, T	vc. 111 50	oth May	w St. Benderville	Pa
1 1 1			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused th one cause on each line.	e death. Do not ent	er the mode of dy	ing, such as cardiac	or respiratory arres	t,	Approximate Interval Between	
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Myocard	itis					Onset and Death	
100	/Medical Examiner		Todaking in dodain,	Due to (or as a d	consequence of):						
14.		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a c	consequence of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause Universe or Myun that initiated events								
o,	be executed ician and burial-transit		resulting in death) Last	Due to (or as a c	consequence of):						
8760,	icate be executed physician and s the burial-transil	dlcal		d							
9	n certific anding p	/Mec	IF FEMALE:	220 If you outcome of	22000000				1		
Вох	atte for	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2   4 Pregnant at time	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	· ·	
P.O.	it the di by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	re or death 5	Ciner (specify) _					
σ,	es that igned b be deta	y P	Part II. Other significant conditions of	ontributing to death but r	not resulting in the ur	nderlying cause giv	ven in Part I.	23e. Did tobac	cco use contrib	ute to the cause of death?	
rds	equire en sig ould b	ed b						1 ☐ Yes	2 <b>X</b> ) No 3	☐ Probably 4 ☐Unknown	i
000	law requas been 2 should	plet						24a. Was an	24b. We	re autopsy findings available	•
Vital Records,		Completed						autopsy performe Yes 2	d? dea	re autopsy findings available or to completion of cause of ath? I Yes 2  Po	
/ita	ician: certific rector,	Be	25. Was case referred to medical examiner?					th (Check only one)			
of	Phyaician: rthis certifica ral director, i	2	1 X Yes 2 □ No 27. Manner of Death	Hospital:	2X ER/Outpatien	I 3LI DOA		ome 5 Residence			
Division of		tlon	1 X Natural 5 Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	28c. Injur Wor M 1	ryat rk? ]Yes 2 □ No	28d. Describe how	injury occurred		
/isi	Attending or death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm, stre		,105 2 0,10	28f. Location (Stree	at and Number	or Rural Route Number.	-
D.	= = = =	Certification:	4 Homicide determined	building, etc. (	Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, S	State)	or visito visito visiti sor,	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	ledical (	(Check only 2 X Medicel Exen	ysicien: To the best of r niner: On the basis of ex	amination and/or inv	occurred at the til	me, date and place, opinion, death occur	and due to the caus	e(s) and mann	er as stated.	-
2007	thin 2 the other		one) 29b. Signature and title of certifier	and manner stated	1.	29c. Licens				Month, Day, Year)	
		-	Anala A	Spoonboo	urin		.M.E.				
	WIL	5	30. Name and address of person who	completed cause of deal	h (Item 23a) (Type I		• 61 • 47 •	F	entuary	22, 2004	_
	ENDIN		7/	burg H.D.		,	, Baltimo	re, Maryl	and 212	201	
	Sta	te	31. Date filed (Month, Day, Year)	92. Registrar's	Signature						-
	Registr	ar	FEB 2 4	2004 Blene	are St	South 8					

T- State of Maryland Registrar	/ Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 06711							
1. Decedent's Name (First, Middle, Last)  Physician  DODOGRIN, MAE LITISON	2. Date of Death Month Day Year  3. Time of Death							
/Medical  /Medical  Examiner  Aa. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  4c. County of Death							
Socred Heart Hospital	Cumberland Allegary							
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. lass	st birthday) Yrs.  If Under 1 Year  If Under 24 Hrs. Months Days Hours Min.  SEPT 28 1928  9. Birthplace (State or Foreign Country) PENNSYLVANIA							
Usual Residence of Decedent	Town or Location 10d. Inside City Limits							
MARYLAND ALLEGANY FRO	DSTBURG 1 □ Yes ※□ No							
MARYLAND ALLEGANY FRO	10f. Zip Code 10g. Citizen of What Country?							
11411 HOFFMAN HOLLOW ROAD, SW  11. Marital Status  1 Never Married 2 Married  1. Yes 2 XNo	21532 U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No-							
MARYLAND ALLEGANY FROM	13. Was Decedent of Hispanic Origin? (Spacify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☒ No Specify:  WHITE							
90 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	16a. Decedent's Usual Occupation 16b. Kind of Business/Industry							
To Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)  HOMEMAKER OWN HOME							
8 In the second of the second	HOMEMAKER OWN HOME  18. Mother's Name (First, Middle, Maiden Sumame)							
THOMAS LONGENECKER  19a. Informant's Name/Relationship (Type, Print)	BERTHA GEARHART							
통 등 등 기9a. Informant's Name/Relationship (Type, Print) SYLVIA DUDLEY / DAUGHTER	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11411 HOFFMAN HOLLOW ROAD, SW, FROSTBURG, MD 21532							
20a. Method of Disposition  20b. Plac  20c.	ce of Disposition (Name of Date 20c. Location - City or Town, State netery, crematory or other place)							
Language Service (Licensee	NDALE CEMETERY 2/29/04 FLINTSTONE, MD  22. Name and Address of Facility 60 W. MAIN STREET							
Marilay M. Sowars	SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532							
23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each tine.	Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Opath							
/Medical Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of the	le Rehal Hallere Solge							
Examiner Sequentially list conditions b.	nic Leval Failure Zyne							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as consequence)  Due to (or as a consequence)	3 cap							
that initiated events c. Due to (or as a consequence of the consequenc	nce of):							
Cause (Disease or injury that initiated events resulting in death) Last  Cuse of the property								
UF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal december 1 □ Live birth 2 □ Fetal december 1 □ Live birth 2 □ Fetal december 1 □ Live birth 3 □ Fetal december 1 □ Live birth 4 □ Fetal december 1 □ Live birth 5 □ Fetal december 1	looth 3 Setopic programmy							
The few results of the state of								
The state of the s								
	1 Yes 2 No 3 Probably 4 Unknown							
The law requirement of	24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?  1							
25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death (Check only one)							
25. Was case referred to medical examiner?  1	R/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  28c. Injury at Work?  28d. Describe how injury occurred work?							
Description of the control of the c	M 1 Yes 2 No							
To the part of the	ne, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only)  29a. Certifier (Check only)  29a. Certifier (Check only)  29a. Certifier (Check only)								
and manner stated.  29b. Signature and title of certifier	on and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
	on and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  29c. License number  29d. Date signed (Montif. Day, Year)							
Kichlud G. Offittel	29c. License Number 29d. Date signed (Month, Day, Year) 2/27/04							
Kichlud G. Offittel								

State of Maryland / Department of Health and Mental Hygien 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Dey Year **Physician** Erma M. Armstrong March 2004 12:59 PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Genesis Eldercare - Cromwell Center Baltimore Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) Funeral Months Days 1□ M 2☑ F Director 217-05-5514 84 Maryland Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Depertment of Health end Mental Hygiene.
Important: If Item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examiner must be notified at proce. 1 ☐ Yes 2 ☑ No Funeral Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Topwood Court 21234 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0026 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: White 3 X Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8th Grade 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Peges 1 end 2 should be John Norwood Iνα Kopp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mr. Wayne Armstrong (son) 8 Topwood Court, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland Parkwood Cemetery 3/5/04 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of): Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and attending physician for use as the buria Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 s 2 No 1 ☐ Yes 2 No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🖾 No 2 ER/Outpatient 3□ DOA this : After this e funerel 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 □ No Il Director: A investigation efter death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. edicai 29a. Certifie (Check only one) 2 29c. License number 29d. Date signed (Month, Day, Yeer) ted cause of death (Item 23e) (Type, Print) BWd Bulhmaom. 5601

State Registrar

31. Date filed (MoMAR, Vear) 4 2004

anneting

Grown

Division of Vital Records, P.O. Box 68760

32. Pegistrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 10:20AM Avaritt March 2064 Thelma /Medical County of Deeth 4a, Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square Hospital SPONE If Under 24 Hrs. (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 10, 1923 Months Days Hours 1 □ M 2 □ XF 80 217-26-9269 Canada Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Count r than "natural", or Iteme 23e or 28a-f ehor tre Medical Examiner must be notified at 1 Yes 2 No Director Dundalk Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 8235 North Boundary Road 21222 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othmany injury or other traumatic event 9DBCB. Pearl Knight Clarence Huffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a Informant's Name/Relationship (Type, Print) 8235 North Boundary Road, Dundalk, Md. 21222 Kenneth Avaritt Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition March 6, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Of Jesus Dundalk, MD. 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. ME /110 Sollers Point Road, Dundalk, Md. 23a. Part1. Entry the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or learn failure. List only one cause of each line. Approximate Interval Between **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Bowe erforated Sequentially list conditions frany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence Due to (or as a consequence of) attending physician Physician/Medical use 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 □ No 3 □ Probably 4 □Unknown 1 Yes cate has been sig page 2 should b Completed chronic Respiratory Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 Z No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Z Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation al or Attend s after death il Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

 $\gamma$ State

To the

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Maryland

Baltimore,

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of Vital

Division

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Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signatu

11. Jason Bir bour 900 Fronklin square Mire Bortinole, mp 21237
31. Date filed (Mognificary, Year) 32. Registrar's Signature

29c. License number

D0056296

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2004 06714 1 - For State Registrar Certificate of Death 2. Date of Death Day Month 35 PM **Physician** ndrews 6: cbruny 25,2004 Warren /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Neme (If not institution, give street and number) Examiner N/A Extended Care more Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-16-18 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 M 2 □ F Yrs. Georgia 85 Director 220-03-4334 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State or than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 □ No Director Baltimore N/A Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 600 Hillview Rd. 21225 USA Completed by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Bleck, White, etc. 1X) Yes 2 No If Yes, Give Year or Dates: 42-45 1 Never Married 2 Married 1 ☐ Yes X☐ No Specify: Baltimore, Maryland 21215-0036 Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) I Hygiene. Balto, City School 12 School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be Fannie Mae Andrews D. Andrews Warren 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gwendolyn M. Andrews Wife 600 Hillview Rd, Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 Cremation 3 Removal from State Crownsville VA.Ce 3-3-04 Crownsville, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lloyd M. Esten

23a. Part 1. Enter the disease, or complication, that caused the death. Shock, or heart failure. List only one cause on each line. Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Leckenia months Acute Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit death certificate be executed Due to (or as a consequence of) attending physicien a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 99 1 Yes 2 No 3 Probably 4 Donknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform 2 No 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 2 ER/Outpatient 2 28b. Time of 28d. Describe how injury occurred completely filled in by the funeral 27. Manne of Death Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 16 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie February 25, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore VAIMC Extended Cure 5 W10 Javid 39. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 4 2004 Registrar

			For Amend Item 22,30 p	Staterop Marylan G82	d / Departme 9, 03/04/04d	nt of Health and le of Death	Mental Hyg	giene 200	06715		
			Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th • Day Yea	3. Time of Death		
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			5. Social Security Number 6. Sex	7. Age (In yrs.	last hirthday) If Und	er 1 Year Til Under 24 Hrs	. B. Date of Birth	1111	Birthplace (State or Foreign		
121	Funeral Director		5. Social Security Number . 6. Sex	V	Yrs. Months			Year) 8	Country) GA		
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	with the		10e. Street and Number	nd .	104. 2	ip Code		1184	Country		
	ne 23	Funeral	11. Marital Status	2. Was Decedent Ever in U	.S. 13. Was Dec	edent of Hispanic Origin? (S	specify Yes or No-		merican Indian,		
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altimore			*4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	e . n	227 Name	and Address of Facility	uanocic	reeno Fu	neral Sentico		
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Box	death ce e attend ed for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)				23d. Date of Month	delivery Day Year		
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	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medi	one)	and manner stated.				29d. Date signed (Mi			
	Vitl To CON	-	29b. Signature and title of certifier		9c. License number						
	$\wedge$		30. Name and address of person who co	moleted cause of death /he-	m 23a) (Tune Print)	02908	5	morch	2 2004		
	4		Allan Jay Chircus,								
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	Regist	rar	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Secretary States of the	0 1						

Baltimore,

Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Unpend Item#23a,27,28a-f,Per ME,C829CB/102/104egf Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 26, 2004 3:27 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland General Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Y 9. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 5. Social Security Number **Funeral** Year) Months 220-06-1222 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at Yes 2 No by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 238 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Never Married 2 Married within 72 hours after Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) of Health and Mental Hygie I Item 27 Is marked other I ir other traumatic event, other 18. Mother's Name (First, Middle, Maiden Sur Name (First, Middle, Last) Be Pages 1 and 2 should be 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Name/Relationship (Type, it of Hears: If Item 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Method of Disposition 2 Cremation 3 Removal from State Department of Important: If any injury or once. 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ereenetureral Stuc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Heroin Intoxication and Cocaine Use /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immuniate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consulpience of): Examiner physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical as attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To To the nuspress after death.
within 24 hours after death.
To the Funeral Director: After th found, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death found'y 2:38 a 1 Natural 5 Pending 1 ☐ Yes 2 🙀 No investigation 2/26/04 unknown 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1512 Futaw Pl., Apt. Al. Baltimore, MD residence Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of O.C.M.E. February 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year, 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

MAR 0 4 2004

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $200 \, \mathrm{L}$ Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** If Under 24 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Hours 232-30-083 Usual Residence of Decedent 1 MM 2□ F Yrs. **Director** permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the M-ulcal Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland

10e. Street and Number Funeral Director nor 10f. Zip Code 10g. Citizen of What Country? Va 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 2No Baltimore, Maryland 21215-0036 Specify: Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) preheur 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print) (daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremation 3 Removal from State 12 2004 Mem. Par \* 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ucensee 22. Name and Address of Facility Joseph Li Funeral Balto Home Th Ave 23a. Part /Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coronary Zdays disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 701 tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of): Examiner been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown tnem. Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 autopsy performed? this certificate 1 Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending Injury 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral I cai 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland MD 1000

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 For State Ragistra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer **Physician** 29,2004 9:25A FLORENCE BYRNE February /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Edenwald Towson Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) Sept. 12,1906 Maryland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 ☐ M 2 🙀 F 97 Yrs. 124-20-0971 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "naturel", or items 23s or 28e-1 show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No XX Directo Maryland Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 800 Southerly Road 21286 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours afternent of Heatth and Mental Hygiene. Int: If Item 27 Is marked other than "naturel", or Ite I ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Department Store Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Richards Florence Wallace Edgar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Kathy Krammer 22 Glenberry Court Phoenix, Maryland 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 3-4-04 \* 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory Baltimore Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld F.H. Inc.
6500 york Road Baltimore, Maryland 21212
Approximately arrest 21. Signature of Funeral Service Licenses Tredo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?

1 ☐ Yes 2 🗷 No

9 ☐ Unknown 4□Pregnant at time of death 5 Other (specify) signed by the a ld be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEGENERATIVE ARTHRITIS 23e. Did tobacco use contribute to the cause of death? Records, by 2 No 1 TYes 3 ☐ Probably 4 ☐ Unknown been si Completed BACT ERURIA CHRONIC 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 this certificate has Division of Vital 26. Place of Death Check on one director, 25. Was case referred to medical Be Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗀 Yes ျှ 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After 1 Natural 5 Pending 1 Tes 2 No death. investigation 2- ☐ Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) --29b. Signature and tire of certifier 29d. Date signed (Month, Day, Year) DOOIY67 Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN 9- NE38-1 THE MO 200 E 200 East 33rd Street Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 4 2004 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 200406719 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** VIRGINIA BURY MARCH 2004 6:30 A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MARINER HEALTH OF FOREST HILL HARFORD FOREST HILL 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 09/25/1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Hours 1 ☐ M 2 X F Davs 84 Director 129-12-1953 North Carolina Usual Residence of Decedent r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MD Harford Havre de Grace Direct the the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 637 North Stokes Street 21078 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status r then "natural", or iten the Medical Examinar Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then eny injury or other traumatic event, the Mean injury or other traumatic event, the Mean injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) unknown Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John A. Sears Vinnia Estell Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frank DiStefano- Son 637 N. Stokes St., Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Angel Hill Cemetery 03/05/04 Havre de Grace, MD 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. 23 S. Washington, Havre de Grace, MD 21078 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ancer /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner o the Hospital or Attending Physician: The law requires that the death certificate be executed and physicien ar s the burial-tr Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 Unknown Records, P. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 3 Probably 2 🗆 No 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To After thi 27. Manney & Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 La atural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. N e an ddress of persor who comple 31. Date filed (Month, Day, Year) State Registrar 2004

**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene 2 ft 0

		-	For State Ragistrar	State of Ma	iryianu / i	Certific	ate of L	Death		Reg. No.	JU4	00120
100	Physicia	an	1. Decedent's Name (First, Middle, La	J.			Boyo	d	2. Date of Dea Month March	Day	Year 2 cc 4	3. Time of Death 5: 45 P M
>	/Medic Examin	10.00	4a. Facility Name (If not institution, given Johns Hopkins	Bayvie		al Center	B	Location of Death	و		ty of Death	
er The	Funeral Director		212-16-0403	Gex 7. Age 1 □ M 2 ▼F	(In yrs. last bi	Yrs. If U	nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da March 2	y, Year)	9. Birthp Cour SC	place (State or Foreign ntry)
	land bw		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Location			-		1	10d. Inside City Limits
	Mary -f sh	ţo	MD. Baltimon	re	Dur	ndalk						1 □Yes 2 X No
	with the	Funeral Director	10e. Street and Number 210 Detroit Avenu	<b>l</b> e		101	. Zip Code	1222		10g. Citizen o		ntry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 is marked other than "natural", or Itema 23a or 28a-1 show other traumatic event, the Modral Examinar must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:				spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	BI	ace - Americ ack, White, ify: Whi	etc.
Maryland 21215-0036	vithin 72 ho ne. hen "natui e Modical	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed) College (1-4or 5		life. DO NO	of work done of OT use retired	during most of wor	king	16b. Kind of		dustry
і В	filed v Hygie other t	e Co	12 years  17. Father's Name (First, Middle, Lasi	t)		Secre	etary	18. Mother's Nan	ne (First, Middle,	Hospi Maiden Suma		
an	d be ental	To Be	James Jackson					Lola F	'ord			
<u> </u>	Shout nd Me mark	Ĕ	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Add	dress (Street a	and Number or Ru		er, City or Tow	n, State. Zip	Code)
	nd 2 alth a 27 Is r trat		Janice B. Evans	daughter	20	08 Deti	coit Av	enue, Dur	dalk,Md	. 21222	2	
Baltimore,	Pages 1 and 3 nent of Health int: If item 27 iry or other tr		20a. Method of Disposition  **Disposition   3 Cremation   3 Crematical   3 Crem	□Removal from State	_	of Disposition ery, crematory n Park		11111		20c. Location		
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Lice	1. (anne	lh	Conr	ne and Address	Tuneral H	lome Of I	Dundalk	100	
	305 m		23a. Part1. Enter the disease or conshock, or heart failure List only	nplications that caused	the death. Do	not enter the	mode of dyin	g, such as cardiac	or respiratory a	rrest,	Ly L'ILL	Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Isch		Bou	wel				-	Onset and Death
	Examiner		1	Atria		ibrill	ation					lyear
		Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence	of):						
,00	tificate be executed ig physician and as the burial-transit	I Examiner	cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):						
68760,	cate b	edical		d								
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deat		pic pregnancy er (specify)				ate of deliventh	ery Day Year
rds, P.O	quires that n signed build be deta	þ	Parll. Other significant conditions Heart Failure	contributing to death b	ut not resulting	in the underly	ing cause giv	en in Part I.				he cause of death?
Vital Records,	The law requir cate has been si page 2 should	Completed							24a. Was autor perfo	an 24b osy ormed? 2 X No	prior to co death?	opsy findings available impletion of cause of
ita	sician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						ith (Check only o	one)		
o	Phys this al dii	2	1 ☐ Yes 2 💆 No  27. Manner of Death 1 🗷 Natural 5 ☐ Pending	Hospital: 1 Sinpatie 28a. Date of Inju (Month, Date	ry 28b.	Outpatient 3[ Time of Injury	DOA Oth	4 🗆 Nursing n	ome 5 Resi			(y)
Division	spital or Attendir ours after death. neral Director: Al	Certification:	2 Accident investigation 3 Suicide 6 Could not determine	be 39a Blace of Ini	ury - At home, c. (Specify)	farm, street, fa		Yes 2 □ No	28f. Location (. City or To		nber or Rura	al Route Number,
۵	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical Cer	(Check only 2 Medical Exa	Physician: To the best	f examination a							
	To the Hos within 24 h To the Fur completely	Med	one) 29b. Signature and title of certifier	and manner sta	ated.		29c. Licens	e number		29d. Date sign	ned (Month	Day, Year)
	To To		Patrick So	may n	10			5-600		March		
	10		30. Name and address of person who Patrick Sosnay	494	leath (Item 23a	) (Type, Print)	Avenue	. Bal	timere,	Marylan	nd a	21224
	St Regist	ate rar	31. Date filed (Month, August)	4 2004 <sup>32. Registr</sup>	ar's Signature	stern I	ask s					

State of Maryland / Department of Health and Mental Hygiene 2004 06721 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year March 2, 2004 12:13 P M Blontz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Eldercare- Heritage Center Dundalk If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛱 F 214-22-3507 87 July 6,1916 Director PA Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits Item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, it is Madical Examiliar I: sust be inclined at 1 ☐ Yes 2 ☑ No Baltimore Dundalk Md. Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1801 Merritt Blvd 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No à Specify: 3√ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) rmit. Pages 1 and 2 should be fitte partment of Health and Mental High portant: If Item 27 Is marked ottry injury or other traumatic evan Minnie Ruhur Roy E. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2205 Searles Road, Dundalk, Md. 21222 Ronald Ankeny son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 3, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit, Page Department o Important: If any injury or Bayview Crematory Baltimore City, MD 2004 21. Signature of Funeral Service Licensee 23. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the diselves, or complications that caused the seth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner inding physician and use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 Ø No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 Donknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 **2** No certificate 1□ Yes Be 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 3□ DOA this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after within 24 hours a To the Funeral I Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signator and title of certifier no completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 06722 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:50 p 28 2004 FEB Raymond Bednar /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1221 Braxfield Ct. Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) FEB 26, 1951 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □XM 2 □ F Pennsylvania 204-42-1758 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County ir than "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2V No Rockville Maryland Montgomery **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 USA 1221 Braxfield Court 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎇 No Specify: White 3 ☐ Widowed 4 ☑ Divorced Be Completed by 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than Hygiene. Manager Restaurant permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyg.
Important: If item 27 is marked other any injury or other treumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Peter Paul Bednar Clara Jagiello 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6228 Dickerson Road Dickerson, MD Raymond Bednar, Jr./Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Inc. 3-1-04 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral in Fineral CA

Dawn F. McDonald Cremation Society of MD 299 Frederick Road Ba 21228 Baltimore. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PATHEROSCIENOPIE CARDIOUASCUMAL DISENSE Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of) 68760 Physician/Medical Box ( IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Wes decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 1 detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate has or Attending Physician: 26. Place of Death (Check on one funeral director, 25. Was case referred to medical examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MO (DME) MAKEY 1,2004 015236 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIE ROCKILLE MO LOSSE I. MARGOLI 11125 ROOK UE 32 Registrar's Signature 2004 State South Registrar

			1 - For Amend Item# 17	State of No.	laryland 29, 3/9	d / Depa 72002 Ce/	artment of I	lealth ar <i>Death</i>	nd Mental Hy	giene 2	004	06723
	Physici		1. Decedent's Name (First, Middle, La	ist)					2. Date of De		Year	3. Time of Death
	/Medic		Patricia R.						Februa	ary 25	, 2004	7:33 PM <sup>M</sup>
1	Examir	er	4a. Facility Name (If not institution, gir				4b. City, Town, o		Death		unty of Death	1 1
-2-			Anne Arundel Med 5. Social Security Number 6.		er age (In yrs. I	ast birthday)	Annapol If Under 1 Year		Hrs. 8. Date of Bir	th.	ne Aru	
	Funeral Director			1□M 2□XF	80		Months Days		Min. (Month, Da	y Year) 29 19	Coul	place (State or Foreign ntry) V land
	p ,		Usual Residence of Decedent		10- 01-	-			00112			
	shov	٦c	Maryland Anne A	rundol		n Burr					1	10d. Inside City Limits 1 ☐ Yes 2√ No
	the N	ect	10e. Street and Number	runder	GIE	II DULI	10f. Zip Code			10a Citizaa	of What Cour	21
	3a or	Ī	1534 Tieman Driv	e			21061			USA	101 What Cour	nu y r
	death	Funeral Director	11. Marital Status	12. Was Deceden			Was Decedent of H	lispanic Origin	? (Specify Yes or No		Race - Americ	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene.  If Itam 27 is marked other than "natural", or Items 23a or 28e-f show or other traumatic avant, the Medical Evanties must be toutified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces  1  Yes 2  If Yes, Give  Year or Dates	ζ <sub>N</sub> ο		fYes, specify Cubi I□Yes 2∏No	Specify:	ruento Rican, etc.)	Sp	Black, White, ecify:	white
9-0	72 hou	ted	15. Decedent's E			16a. Deced	lent's Usual Occup	ation	(	16b. Kind	of Business/In-	dustry
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Maryland 21215-0036	ld be fi ental H ked otl	To Be	17. Father's Name (First, Middle, Last	ERNEST CAI	RROLL B	ROCH			Nam <i>e (First, Middl</i> e olyn Lair	, Maiden Sui	mame)	
ary	should and Men s marke turnatio		19a, Informant's Name/Relationship			19b. Mailin	g Address (Street		or Rural Route Numb	er, City or To	wn, State, Zip	Code)
	and 2 Balth a n 27 Is		Leona M. Messeng	er/Niece			Tieman D	rive	Glen Burr	nie, M	D 2106	5 <b>1</b>
Baltimore,	Pages 1 nent of He int: if Itan		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Removal from State		ace of Dispos metery, cren	sition (Name of natory or other plac	· 1	Date	20c. Locati	on - City or To	wn, State
ţ	. Pag tment tant: tant:		* 4 □ Donation 5 □ Other (Speci	(y)	Met	ro Cre	ematory I	$nc. \mid 2$	-27-04	Balt:	imore,	MD
Bal	permit. Pages 1 an Department of Heal Important: if Itam 2 any injury or othar once.		21. Signatur of Funeral Service Lice	recordbas	ordet	22	Name and Addre Cremation 199 Frede	ss of Facility Socie rick Re	ty of MD,	Inc.	. MD 2	21228
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the death. line.	. Do not ente	or the mode of dyin	g, such as car	rdiac or respiratory a	rrest,	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Bre	out	(0	ucer		Melasta			Onset and Death
0	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ence of):						
ũ	40	e.	Sequentially list conditions,	b. Due to (or a	a d Lufiatiqu	ence on.						
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8760,	icate be executed physician and s the burial-transit	dical		_ d								
9	ertifica ling pl	Med	IF FEMALE:			-			-			
Вох	leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3□	Ectopic pregnancy			23d.	Date of delive Month	ry Day Year
0	that the death ed by the atte detached for	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9□ Unknown	at time of de	atn 5⊔	Other (specify)					
<u>α</u>		by Ph	Part II. Other significant conditions	contributing to death	but not resul	lting in the un	derlying cause give	en in Part I.	23e. Did to	obacco use o	contribute to th	e cause of death?
Vital Records,	w requires been sign should be	ed b	General	Debulu	<u>ty :</u>				_ 101	res 2□N	o 3 🗆 Probi	ably 4 Unknown
000	law re	piet			•				24a. Was		b. Were autor	osy findings available
č	ician: The lar certificate has ector, page 2	Completed							- autop perfo 1 ☐ Yes		death?	npletion of cause of 2□ No
/ita	cian: ertificactor,	Be (	25. Was case referred to medical examiner?					26. Place of	Death (Check only o	/		20110
	ding Physician: The Ih. h. After this certificate ha funeral director, page	္	1 ☐ Yes 2 No	Hospital: 1 X Inpat		R/Outpatient		4 🗀 Nursir	ng Home 5 ☐ Resid	lence 6 🗆	Other (Specify	')
n	ding F	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe h	now injury oc	curred	
Division of	l or Attand after death Director: A in by the f	icat	2 Accident investigatio 3 Suicide 6 Could not b	e 29a Place of le	iupy - At bon	ne form stee	M 1 1	Yes 2 □No	29f Loggting (6	Para at a and Al.	umbaa aa Duur	Courte Mountain
.≥	al or A after I Dire d in by	Certification:	4 Homicide determined	building, 6	tc. (Specify)	ne, iami, stre	et, factory, office		28f. Location (S City or Tox		imber or Hurai	Houte Number,
	To the Hospital or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical (	29a. Certifier   1 Certifying Ph (Check only one) 2 Medical Example   Medical Exampl	nysician: To the best miner: On the basis and manner s	or examination	rledge, death on and/or inv	occurred at the timestigation, in my of	ne, date and pl pinion, death o	ace, and due to the occurred at the time,	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)
	To th within To the compl	Me	29b. Signature and title of certifier			-	29c. License	number		29d. Da <b>j</b> e sig	ned (Month, E	Day, Year)
			ADITIA	Cyop	RA		D570	028		2/20	5/04	
	0		30. Name and address of person who			23a) (Type, F	231 A	nabi	Dis W	02	14x1	
	Sta	te	31. Date filed (Mortin R.P. Year)	004 32. Regist	rar's Signatu	ILE C		i coy	,,,,,	9	-101	
	Registr		U # 2	004	un s	de de	ack)					

State of Maryland / Department of Health and Mental Hygiene 2001

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	-	alle.			

				Ce	rtificate of	Death		Reg. No.	04	00124
	<b>.</b>	1. Decedent's Name (First, Middle, La	ist)				2. Dete of D		.,	3. Time of Death
	Physician	Darlene		Br	ewer		Month	Dey	Year 2004	11.38am
1	/Medical Examiner	4e Fecility Name (If not institution, giv	re street end number)			4b. City, Town, or				110
	Examiner	Stella Maris	Mercy			Balti	more	N/		
	Eumoval	5. Social Security Number 6. 5	-	(In yrs. last birthdey	If Under 1 Year	If Under 24 Hrs	8. Date of B	irth	9 Birthol	lece /State or Foreign
	Funeral Director		1□ M 2√ F 37		Months Days	Hours Min.	8. Date of B			lece (State or Foreign try)
		Usual Residence of Decedent				1	5-21	-66	Md.	
	y #	10a. Stete 10b. County		10c. City, Town or Lo	ocation			-	10	0d. Inside City Limits
	Me.	Md. Anne Ar	undel Co.	Ođe	nton					V☐ Yes 2☐ No
	15e 128 19e	10e. Street end Number	ander co.		10f. Zip Code			10g. Citizen of	What Count	21
	with on the state of the state	1264 Lucinda La	ne		2111	L3		USA	THE COUNT	.iy:
	be filed within 72 hours efter death with the Merylend net lygiene.  And thygiene.  Be dother than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at Be Completed by Funeral Director.	44.14.24.20.2	10 Was Decedes F	in 11.0	Was Danidad of I	V	7 17	14 000		
	P F P	11. Mantel Status	12. Was Decedent En Armed Forces?		Was Decedent of H If Yes, specify Cub	an, Mexican, Puert	pecity Yes or N o Rican, etc.)	0- 14. Had Bla	ce - America ck, White, e	
20	s eft	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes ZX No	9	1 □ Yes <b>3/</b> □ No	Specify:		Specif	Blac	.l.
21215-0020	bour d b		Year or Dates:							
5	led within 72 ho ygjene. Ner than "natura Nt, the Medical I	15. Decedent's Ed (Specify only highest great	ducation ade completed)	16e. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	etion during most of wor	rking	16b. Kind of B	usiness/Ind	ustry
2	D P C	Elementary/Secondary (0-12)	College (1-4or 5+	.)						
	Hygie ther ther ther ther ther ther ther the	12th grade		Nev	er Worked			NA		
n n	Be en H	17. Father's Neme (First, Middle, Lest,	,			18. Mother's Nar	ne (First, Middle	a, Maiden Surnan	10)	
<del>S</del>	should be and Mentel I marked of umatic eve	John	Br	rewer		Betty		Mund	ell	
Maryland	2 should be filed within end Mentel Hygiene. Is marked other than surmatic event, the March To Be Comp	19e. Informant's Name/Relationship (			ng Address (Street				State, Zip	Code)
		June Hebron S	ister	1264	Lucinda	Lane, Od	enton,	Md. 211	.13	
Z	ges 1 end t of Health If item 27 or other t	20a. Method of Disposition		20b. Place of Dispo cemetery, cre-	sition (Name of	ce)	Date	20c. Location -	City or Tov	vn, State
Ĕ	® € ÷ >	1 XBurial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		St. Res			3-5-04	Hanove	r. Md	
Baltimore,	in property	21. Signature of Funeral Service Licer	1890	2:	2. Name and Addre	ss of Facility		more, Mo		.202
ä	Bany any	1. 11	ho		March F.H	J Foot		E. North		
		1 Complete Total House Complete								
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one gause on each line	e death. Do not en	er the mode or dyir	ig, such as cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Final								Onset and Death
	Examiner	disease or condition resulting in death)	a	bern	st cy	Ner			; L	
\	<b>1</b>		D	ue to (or as a conse	quence of):					
W	olu sit		b. ———						i	
•	certificate be executed rightly physicien and use as the buriel-trensit	Sequentially list conditions,	D	ue to (or as e consec	juence of):					
90,		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	C							
68760,	certificete be nding physicie use es the bui	that initiated events resulting in death) Last	D	ue to (or as a conseq	uence of):					
9 x c	ing p		d						į	
			0							
<u>.</u>	sic sic	Part II. Other significent conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23b. Did	tobecco use cor	ntribute to	the cause of death?
P.O.	The lew requires that the deeth stee hes been signed by the etter page 2 should be deteched for a completed by Physicial						1 🗆	Yes 2 No	3 Prob	ably 4 Unknown
ŝ	es the igned be de									
Ď	quire						24a. Was	an autopsy		re autopsy findings ilable prior to
S	s be						peni	ormed?	com	pletion of cause eeth?
of Vital Records,	The lew requir						10	va ofw		
		25. Was cese referred to medical				00 81 (8			10	Yes 2□ No
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of	Phys reldi	27. Manner of Death	1 ☐ Inpatient	2 ER/Outpatier	I 3LI DOA	4 LI Nursing H	ome 5 Resi	how injury occurr		hospice
on	or Attending Fafter deeth. Director: After in by the funer	1 Natural 5 ☐ Pending	(Month, Dey	Year) Injury	28c. Injur Worl M 1 □	k?` Yes 2∐No	200. 00301100	now injury occurr	60	
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Division	tal or Attending P rs efter deeth. al Director: After t ed in by the funer. Certification:	4 ☐ Homicide determined	building, etc.	y - At home, farm, str (Specify)	eet, factory, office		City or To	Street and Numb wn, State)	er or murar.	Hoble Williber,
_	Pital Surs Filled	200 Continue de Continue de								
	To the Heapttal or Attendit within 24 hours effer deeth. To the Funeral Director: A completely filled in by the t Medical Certificati	29a. Certifier (Check only one)  Certifying Physical Example (Check only one)	ysician: To the best of entirer: On the basis of e	xamination end/or in	occurred et the ting estigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and ma date and place, a	nner as sta and due to t	ted. the cause(s)
	Thin the maple	29b. Signature end title of certifier	and menner state	90.	29c. Licens					
	P N N	200. Signature and title of certifier	<b>\</b>		250. Licensi	CC 1 I		29d. Date signed	(Month, D	ay, rear)
		D1 10	1 -		1040	PC BC		3111	200,	7
	14	30. Neme end address of person who	completed cause of dea	ith (Item 23e) (Type,	Print)	0				
		David, Risebe	rg. 301	ST PAUL	PL.	15a/to.	md.	2120	2_	
	State	31. Dete filed (Month, Day, Year)  MAR 0 4 2004	32. Registrar	s Signature						
	Registrar	MAR 0 4 2004	C 11 1000 600 and and	A STATE OF						

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1			nt's Name (First,	Middle, Last)	VACI	lia I	Dorr (	2=				2. Date of Dea Month	Day	Year	3. Time of Death
	Physician /Medical					lie J.	Darr,		Town or	Location of	of Death	FEBRUA	1	3 , 2004 County of Death	2:41 a M
	Examiner		Name (If not inst					TOWS		Location	or Doain			LTIMORE	
× 1	Funeral Director	5. Social S	954 Number 31-58-0092	6. Sex		Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da May 8	h Year) 3, 1937	9. Birth Cou	place (State or Foreign ntry) SC.
21800	ъ	Usual Res	idence of Decede			10c. Cit	y, Town or Lo	ocation					-		10d. Inside City Limits
	Maryla is a show is a show	Mary		N/A											1 Yes 2 No
	be filed within 72 hours after death with the Maryland hall tygiene.  ed other than "natural", or terms 23a or 28a-f show event, the Medical Examinational bundling at the Medical Examination and the hours at the modified at the Medical Examination and th	350	t and Number  1 Elderado	Ave.				10f. Zip	Code	212	207		10g. Citiz	en of What Cou U.S.	
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980	urs after death very or items 23e	1 □ Ne	ever Married 2		1 ☐ Yes 2 If Yes, Give Year or Date			1 🗆 Yes	2 <b>X</b> No	Specify:				Specify:	Black
5-0	ed within 72 hou vgiene.  Vgie			cedent's Educa highest grade o			(Give	dent's Usua kind of wo DO NOT us	rk done	during mos	st of work	ing	16b. Kin	d of Business/li	
121	filed within Hygiene.  Hygiene.  Ather than and, the Mere	Elemen	tary/Secondary (0	)-12)	College (1-4	4or 5+)	me.			e Oper	ator			Koppers	/ Kaydon
and 2	be filed with ntal Hygiene ed other than event, the base Comi	17. Father	's Name (First, M	liddle, Last) Leroy C.	. Barr					18. Moth	er's Name	e (First, Middle, Li	<i>Maiden S</i> urean		
Maryland 21215-0036	ges 1 and 2 should be filed to the death and Mental Hygie If itam 27 is marked other or other traumatic event.	19a. Infor	mant's Name/Re idette Barr		a, Print)		19b. Mail	ing Address 501 Eld	(Street	and Numb	er or Run Baltimo	al Route Number ore, Maryla	er, City or nd 212	Town, State, Z 07	ip Code)
Baltimore,	Pages 1 and nent of Health int: If item 27 iry or other ti	1 □	od of Disposition  Burial 2 Crem  Conation 5 0		moval from S	1 ,	Place of Disp cemetery, cre Kin	osition (Nai matory or c g's Mem	ther plac			03/06/04		ation - City or 1 andalistow	own, State n , Maryland
alti	permit. Pages Department of Importent: If if any injury or c once.	21. Signa	iture of Funeral S	ervice Licensee	7		2		step E	Brothers	s Fune	ral Home F		5.00°	
<u> </u>	90 5 6 9	100	t1. Enter the dise	1.//-	tions that as	used the deal	th. Do not en					Saltimore, N		17	Approximate Interval Between
68760,	es that the death certificate be executed  sympletic and the attending physician and be detached for use as the burial transit  by Dhysician/Medical Examiner	Sequenti if any, lea cause. E Cause (I that initia	ck, or heart failur le Cause (Final or condition in death)  ally list conditions ading to immedia inter Underlying isease or injury ted events in death) Last	( a.	Due to (d	or as a consector as	quence of):	wils	u d	LC.	ay	licety	713		Onset and Death
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Q.	requires that the been signed by the hould be detache	a Faith.	ther significant o	onditions cont	ributing to de	ath but not re	sulting in the	underlying	cause giv	ven in Part	1.		tobaccou: Yes 2[		the cause of death?
Record	The law require cate has been signate page 2 should to											24a. Was auto perfi 1 \( \text{Yes}		24b. Were au prior to death?	topsy findings available completion of cause of
/ital	certificate	25. Was	case referred to		ospital:				Ott			th (Check onl		<b></b>	/
A Division of Vital Records.	2 S 2 9 (	27. Manr 1   1 2   2 3   1 4   1	Accident Suicide 6 Homicide	Pending Investigation Could not be determined	28a. Date of Month	of Injury th, Day Year) of Injury - At Ing, etc. (Spec	ity)	ol M street, lacto	28c. Inju Wo 1 C	ry at irk? ]Yes 2[	KNO	Belte.	Street and	y occurred Then of d Number or Ri Libert	muck by with a rail Acute Number, Hoght Noval
	Hospital 24 hours a Funaral etely filled	29a. Ce (C)	neck only 2🔼 N	ertifying Physi ledical Examin	ician: To the er: On the ba and mann	isis of examin	nowledge, dei nation and/or	ath occurred investigatio	aitneti n, in my	ime, date a opinion, de	and piace ealh occu	rred at the time	, date and	place, and due	to the cause(s)
	To the within 2 To tha complet	29b. Sig	nature and title of	certifier	Vix	mis.		29		se number	r			e signed (Mont. JARY 28	
	0	30. Nam	ne and address of	person who con	mpleted caus	e ol death (Ite	em 23a) (Typ	e, Print)	enn	Stree	et, B	altimor	e, Ma	aryland	21201
	State Registra	-	filed (Month, Da			egistrar's Sign	nature	rela)							
	E.		111111111111111111111111111111111111111	2 2001	S. Landson		1								

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\, \Omega\, \Pi\, \Box$ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 200° 13:55 M Physician Har 26 Veu /Medical 4c. County of Death Jown, or Location of Death 4b. City. 4a. Facility Name (If not institution, give street and number) Examiner mari mor ff Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year Birthpface (State or Foreign Country) Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days M 2□F Months 19-0 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Loca 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f show other traumatic event, the Medical Exeminer must be notified at Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ian death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 Yes 2 100 ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation ve kind of work done during most of working

DO NOT use retired) than Elementary/Secondary (0-12) Colfege (1-4or 5+) f Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 10 2 19b. Mailing Address (Street and Number or Rural Route Number, Sity or Informant's Name/Relationshi (Type, Print) Town, State, Zip Code) AMO. MO 20c. Location - City or Town, State Place of Disposition cemetery, cremator Date lethod of Disposition (Name of permit. Pages 1
Department of H
Important: If ite
any injury or ot Burial 2 Cremation 3 Removal from State □Donation 5 □ Other (Specify) 21. Signature of Fune I Service Licent Ne.1 22. Name and Address of Facility Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caused or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** men /Medical Due to (or as a consequence of) **Examiner** Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner detached for use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 **N**No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 1 ☐ Yes 20 No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 1 Tyes 28a. Date of Injury (Month, Day Year) 27. Manne of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funaral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Funa completely fi (Check only one) and manner stated 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier March 1, 2004

Registrar

State

30. Name and address of person who

65

31. Date filed (Month, Day, Year)

Char

Redgett

MAR 0 4 2004

Lock Raven

Beltonore, and 21239

ompleted cause of death (Item 23a) (Type, Print)

500

32. Registrar's Signature

#### 6:30Am Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06727 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Lest) FERRUARY 28, 2004 Day 6:30 Am Physician **HENRY** BERNHEIMER, JR. .I /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c./County of Death Examiner 28 STELLA MARIS AT MERCY MEDICAL CENTER BALTIMORE If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number Funeral Months Days Hours 1 KXM 2 □ F 83 Director 214-14-8830 MARCH 17, 1920 MARYLAND Usual Residence of Decedent death with the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 🛠 No MARYLAND ANNE ARUNDEL LINTHICUM Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number ERNHEIMER, HENRY **523 CLEVELAND ROAD** 21090 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status XX Yes 2 No NAVY 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ X Yo Specify: Specify: WHITE Completed by 3 XXidowed 4 Divorced Year or Dates: WW | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 end 2 should be filad within Health end Mantel Hygiene. em 27 ie merked other than \* Elementary/Secondary (0-12) College (1-4or 5+) PLANT ENGINEER HOUSE OF GOOD SHEPHERD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HENRY J. BERNHEIMER, SR. **ELMA BURROUGHS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6226 WOODLAND ROAD, LINTHICUM, MARYLAND 21090 HENRY J. BERNHEIMER, II - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Important: If Iter any Injury or oth MX Burial 2 Cremation 3 Removal from State MEADOWRIDGE MEMORIAL PARK 3/3/2004 ELKRIDGE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FINK FUNERAL HOME, PA RELLY CRECORY FINK #M01148 426 CRAIN HIGHWAY S., GLEN BURNIE, MARYLAND 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of Examine or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 6876 Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tyes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 32 No Certification: To 1 Tes Aftar this funerel 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A complately filled in by the fu investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 311/2004 D40854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15-17 mose St Paul 21202 コーした 301 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 04

DHMH 16 Rev 6/95

		-	For State Registrar	State of Mary	land / De/ C	epartment of F Certificate of t	lealth and Death	d Mental Hy	rgiene 20	04 06728
	Physicia	an	1. Decedent's Name (First, Middle, ERNEST	Lest) BALL				2. Date of Do Month Penru	oury 24, 20	3. Time of Death
	/Medic Examin	er	Na. Fecility Name (If not institution,	give street and number) encyal Hos	pital	4b. City, Town, o  BALTIM	ORE	eeth	4c. County of N/A	Deeth  9. Birthplace (State or Foreign Country)
	Funeral Director		212-32-5066 Usual Residence of Decedent	XIXM 2□F	67 Yr	Months Davs	Hours N	Nov 3		MARYLAND
death with the Maryland	r 28a-f show	tor	10a. State 10b. County  ARYLAND N/A		Dc. City, Town	or Location				10d. Inside City Limits 1
di di di	a or 28a	Direc	10e. Street and Number  1102 DOLPHIN			10f. Zip Code 212	17		10g. Citizen of Wh	
<u>i</u>		by Funeral	11. Marital Status  1 XNever Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces?		13. Was Decedent of F If Yes, specify Cubi 1 ☐ Yes 2 ☒ No		(Specify Yes or Nuerto Rican, etc.)		American Indian, White, etc.
and 21215-0036	be lied within 72 hours ital Hygiena. d other then "nsturel", svsnt, the Weulgal Exe	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) unknown	s Education t grade completed)  College (1-4or 5+)		decedent's Usual Occup Give kind of work done life. DO NOT use retired DISABLED	during most of	working	16b. Kind of Busi	
0 P	be illed ital Hygied of other svent, I	Be Co	17. Father's Name (First, Middle, L	ast)					e, Maiden Sumame,	
	should to and Ment marked umatics	P	GEORGE FLEMMI  19a. Informant's Name/Relationsh		19b. I	Mailing Address (Street		A BALL Rural Route Num	ber, City or Town, S	tate, Zip Code)
Z Z	permit. Peges 1 and 2 should be liled within Department of Health and Mental Hygiena. Important: If Item 27 is marked other than any injury or other treumatic svsnt, tha Ma ODGe.		Fannie Powell/ 20a. Method of Disposition 1 Burial 2 M Cremation	Aunt 3 □Removal from State	20b. Place of I cemetery	L McMechan Disposition (Name of crematory or other pla	ce)	Date	20c. Location - C	Maryland  Town, Stete  RE, MARYLAND
Baltimore,	permit. Pe Departmen Important any injury		*4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service I		METRO (	CREMATORY  22. Name and Addre WILLIAM C  1206 W NOR	ss of Facility BROWN	3-0 <u>2-04</u> COMMUNITY JUE		
d	cate be executed Medical bhysician and the burial-transit the burial-transit	ai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	consequence of	·):			- 10 AL	
P.O. Box 687	To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death. To the Funarel Diractor: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tin	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date Mont	of delivery th Day Year
ds, P	uires that signed b id be deta	d by Pł	Part II Other significant condition	hose Hema-	not resulting in	the underlying cause gr	ren in Part 1.			bute to the cause of death?  3 Probebly 4 Ponknown
Recor	The law requires ate has been sign page 2 should be	Complete	Cardiomyop Hepatic Fai	outhy				24a. We aut per 1 🗆 Yes	opsy formed? pr	fere autopsy findings available for to completion of cause of eath? ☐ Yes 2☐ No
of Vita	tending Physician: The leath.  tor: After this certificate the funeral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Menner of Death	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)		patient 3LI DOA	her: 4 🗆 Nursi		one sidence 6 ⊡Othe e how injury occurre	
Division of Vital Records,	il or Attanding Falter death. I Diractor: After d in by the funer	Certification:	1 ØNatural 5 Pendin investi 3 Suicide 4 Homicide determ	gation not be see Place of Injury	y · At home, far		]Yes 2 □No	28f. Location	(Street and Numbe own, State)	r or Rural Route Number,
	To the Hospital or All within 24 hours after or To the Funerel Direct completely filled in by	Medical C	(Check only 2 Medical one)	ng Physician: To the best of Examiner: On the basis of e and manner state	xamination and	Vor investigation, in my	ime, date and popinion, death	place, and due to the	e, date and place, e	nner as stated.  nd due to the cause(s)  (Month, Day, Year)
		2	29b. Signature and title of certifie		oth (Itom 00-)	89	506		2-0. Date signed 2-0	4-04
	3		Shahi C W	azer Ni	> %	manjle	and	Genera	al Ho	spital
	St Regis	ate trar	31. Date filed Month, Pay, Year)	32. Registrar	s Synature	rock				

State of Maryland / Department of Health and Mental Hygiene 2004

Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Pebruary 28, 2004 7:15 p. Paul Grant Biblehimer **Physician** /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Ellicott City Howard Millenium Health & Rehab Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) Sex 1M M 2□ F **Funeral** Deys Hours 86 Yrs. 179-18-1660 Pennsylvania Director December 17, 1917 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County item 27 is marked other than "natural", or items 23s or 25s-1 show other traumetic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Columbia Directo Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21045 U.S.A. 8561 Davis Rd. by Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 X yes 2 No 19
K Yes, Give Yeer or Detes: 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours effer on ant of Heelth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married 1944 1□ Yes 2 No White Baltimore, Maryland 21215-0020 1946 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Kaiser Alum. Elementary/Secondary (0-12) College (1-4or 5+) Machinist 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Anna Shoup John Biblehimer 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8561 Davis Rd. Columbia, Maryland 21045 Mr. Michael Biblehimer Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Depertment of Importent: If it any injury or o 03/03/2004 Ellicott City, Maryland Good Shepherd Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Is Slack Funeral Home, P.A. e; the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, learn failure. List only one ceuse on each line. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final diseese or condition resulting in death) ASPIRATION /Medical Examiner Physician/Medical Examiner CANCER FACIAL ng physicien end es the burial-trensit To the Hospital or Attending Physician: The law requires thet the death certificete be executed Due to (or as e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury Division of Vital Records, P.O. Box 68760. that initieted events resulting in death) Lest Due to (or as e consequence of): for use es 23b. Did tobecco use contribute to the cause of death? ed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably Unknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were autopsy findings available prior to 24a. Wes an eutopsy performed? completion of cause of death? within 24 hours effer death.

To the Funeral Director: Affer this certificate has a completely filled in by the funerel director, page 2: 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 No 2 ER/Outpatient 3□ DOA Mursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Tes 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Deeth 1 Naturel
2 □ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 \ Homicide certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature end title of certifier 04 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Rd Ste Frederica 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State MAR 0 4 2004 Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Man	yland / Depa <i>Ce</i>	artmen rtificat	t of H e of L	ealth a Death		R	eg. No.	04	067	130
	Physicia	20	1. Decedent's Name (First, Middle, Las							<ol><li>Date of Dea Month</li></ol>	Day	Year	3. Time o	
	/Medic		HERM/			BAYL		1 4		MARCH 1	1		3:25	P <sup>M</sup>
}	Examin	er	4a. Facility Name (If not institution, give 3501 ENGLEMEADE I			4b. City,	iown, or	Location of	TIMOR	F	4c. Count		' LTIMOR	Г
	<b></b>		5. Social Security Number 6. Se		n yrs. last birthday)	If Under		If Under 2	24 Hrs.	8. Date of Birth	1	9. Birth	place (State	
	Funeral Director		220-36-4309	ZM 2□F	88 Yrs.	Months	Days	Hours	Min.	JAN. 28	1916	Col	intry) M	D
	pu ,		Usual Residence of Decedent  10a. State 10b. County	11	Oc. City, Town or L	nontion.							10d. Inside C	ity Limits
	anyla shov	ក	MD BALT			IMORE								2 No
	the M	ecto	10e. Street and Number	INOKE	DALI	10f. Zig				1	I 0g. Citizen of	What Col		^
	3a or	Ö	3501 ENGLEMEADE	ROAD				2120	าล				U.S.A	
	death ms 2	nera	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U.S. 13.	Was Dece	dent of Hi			cify Yes or No-	14. Ra	ce - Amer	ica <i>n</i> Indian,	•
ထ္ထ	after or Ite	正	1 Never Married 2 Married	1 MYes 2 ☐ No If Yes, Give		1 Yes		Specify:	, , , , , , , , , , , , , , , , , , , ,	,	Specia		WHITE	
21215-0036	within 72 hours after death with the Maryland ene. Than "naturel", or Items 23a or 28e-f show te Marical Examirer mast be mailised at	Completed by Funeral Director	3 Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a Dace	dent's Usu		ation			16b. Kind of E	tusiness/l		
7	in 72	lete	(Specify only highest gra	de completed)	(Give	kind of wo	rk done a	luring most	of workin	g	TOD. TUNG OF E	4317033411	,,ddSii y	
212	d with giene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	5+ FAMI	LY PH	HYSIC	CIAN			MEDICI	NE		
nd	be tited within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or liems 23a or 28e-f show other than "natural", or liems 23a or 28e-f show event, the Mariest Examir or nest be mailified at	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle,	Maiden Sumai			
Maryland	should be filed withir nd Mental Hygiene. marked other than imetic event, the M	2	LOUIS		BAYL				INA				ENSTEI	N
Jar	2 2 3 3		19a. Informant's Name/Relationship (7		1.	-				Route Number				
	s 1 and if Health item 27 other tr		ERIC BAYLUS / SON		20b. Place of Disp	osition (Na	me of	T		-	20c. Location			
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		1 ☐ Burial 2 🖾 Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cre HILLTOP S			<sup>ச)</sup> )RP.¦3	1/3/2	บบร	TOWS	ON t	ΝD	
Ħ	nit. P artme ortan injuri		21. Signature of Funeral Service Licen							LEVINS				
Ba	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		1 Colean The							OAD - F				208
			23a. Part1. Enter the disease or com- shock, or heart failure. List only	olications that caused the									Approxima Interval Be	ite etween
1	Pnysician		Immediate Cause (Final disease or condition	_ ,	ro vase	Ma	~	A CO	ک نے	ent			nset and	
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):									
	LAdrimiei	_	Sequentially list conditions,	b. — Due to (or as a c	consequence of):							-		
	ted	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	200 10 (0) 43 4 0	onsoquanos or,							1		
۲۰	execun n and ial-tra	Exar	that initiated events resulting in death) Last	Due to (or as a c	consequence of):									
760	ate be executed hysician and the burial-transit	call		d										
89	rtifical ng phy as th	Jedi	IF FEMALE:										-	
Вох	death certifica e attending ph id for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 (	Fetal death 3	⊒Ectopic p						ate of deli-	very Day	Year
о. П		/s c	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne of death 51	Other (s	oecify)							
٥	The law requires that the doute has been signed by the bage 2 should be detached		Part II. Other significant conditions of	ont/ibuting to death but /	not resulting in the	underlying	cause give	en in Part I.		23e. Did to	bacco use cor	tribute to	the cause of	death?
of Vital Records,	uires sign kd be	d by								1 🗆 Y	es 2 🗆 No	3 🔲 Pro	bably 4 ⋤	Onknown
CO	w requir been si should	lete								24a. Was a	an 24b.	Were au	topsy findings	available
Re	The law ate has page 2 s	Completed								autop: perfor		death?	ompletion of 2 ☑ No	cause of
ital		Be C	25. Was case referred to medical					26. Place	of Death	(Check only or				
<b>5</b>	dis d	10	exami <i>n</i> er? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie			4 🗆 140	rsing Hom		ence 6 □Ot		ufy)	
		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. Time (		28c. Injun Work			8d. Describe h	ow injury occu	rred		
sio	eatleatl or:	catl	2 Accident investigation 3 Suicide 6 Could not b		. At home farm s	M factor		Yes 2□I		8f. Location (S	itreet and Num	ber or Ru	ral Route Nu	mber.
Division	i Dir	Certification:	4 Homicide determined	building, etc.	(Specify)	ileet, lactor	y, onlog			City or Tow		007 07 170		
_	Hospita 14 hours Funerel tely fillec	Medical C		ysician: To the best of a niner: On the basis of ea and manner state	kamination and/or is									(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29	c. License	e number	·		29d. Date sign	ed (Month	, Day, Year)	
	->-0		1 Cer 1	De	MS		DI	416	14		Marc	2 6	1,20	04
	10		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type	, Print)			1		vd h		4. 1	A
	10		Hay 15.	Italle	, MW	79	1 70	Cav	rphe	N 181.	VX h	Jhite	March	MW
	Sta Regist	ate	31. Date filed (Month, Day, Year)  MAR 0 4	32. Registrar's	S SIGNATURE	Ly	hom	400	u.1					

		1	For State Registrar		C	Pertificate of	Death		. No.	3. Time of Death
	/sicia	n	Decedent's Name (First, Middle, La  JULIA MAE CO	zart				EBRUHIZY	Day Yea	
3.	ledica amine	er	a. Facility Name (If not institution, giv	e street and number)			r Location of Death		4c. County of De	eath
				ALTHCARE	(In yrs. last birthe		MORE	B. Date of Birth	9.5	Airthplace (State or Foreign
Fun Dire		-	5. Social Security Number  6. S  241-34-2529  Jayal Residence of Decedent	□M 2X)F	9 Yr	Months Days	Hours Min.	3. Date of Birth (Month, Day, Y		Birthplace (State or Foreign Country) NC
the Maryland	THE PARTY	5	10a. State 10b. County		Pumphre					10d. Inside City Limits 1
the M 28a-f	The second	ect	MD ANNE ANNE	ARUNDEL	Tumpiii	10f. Zip Code		100	g. Citizen of What	Country?
th with	90 10		5903 BELLE GROV	E ROAD		2	1225		US	A
er dea		by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 Yes 2000	er in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2000	lispanic Origin? (Spec an, Mexican, Puerto R Specity:	ify Yes or No- ican, etc.)	Black, W	
5-003	-	q pa	3√Widowed 4 □ Divorced  15. Decedent's E	Year or Dates:	16a. D	ecedent's Usual Occup	pation	16	6b. Kind of Busine	BLACK ss/Industry
21.57 dir. 18	event, the Medical	Completed	(Specify only highest grant [Secondary (0-12)]	ade completed)  College (1-4or 5+)		lecedent's Usual Occup Give kind of work done ife. DO NOT use retire	during most of working d)	7		
laryland 2121 2 should be filed within and Mental Hygiene. Is marked other than	2	E O	10			HOMEMAKER			HOME	
aryland 2 should be filed nd Mental Hygi	event	Be (	17. Father's Name (First, Middle, Last	)			18. Mother's Name		aiden Sumame)	
Yla nould 1 Men	natic	ဥ	CHARLES DARGAN  19a. Informant's Name/Relationship (	Time Print)	19b J	Mailing Address (Street	JULIA ]		City or Town State	Zin Code)
Mar d 2 st th and 7 Is n	traun		JUDY MERCER/DAUG			903 BELLE				1225
Baltimore, Maryland 21215-0036  Department of Health and Mental Hygiene.  Titlem 27 Is marked other then "natural", or moortant: If item 27 Is marked other then "natural", or	any injury or other traumatic once.		20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other pla	Da	te 20	Oc. Location - City	or Town, State
MOT Pages nent of Int: If it	y or		1 ♣ Burial 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Speci		MT. C		3/5/20	004 В	ALTIMORE	, MD
<b>Baltii</b> permit. F Departm Importar	i i i		21 Signature of Funeral Service Lice	-	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ss of Facility JAM	-		ONS F.H., INC
m For	£ 8		James 9	Worter	n		AURENS ST.		IORE, MD	21217
			23a. Lent1. Enter the disease, or con shock, or heart failure. List only	plications that caused to one cause on each line	he death. Do no	t enter the mode of dyi	ng, such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
Physic	_		Immediate Cause (Final disease or condition	RESPI	RATOR	27 FAIL	URE			2 DAYS
/Med Exam	_		resulting in death)		consequence of					SLAAC
}		7	Sequentially list conditions,	D	MOM on the same of					1,3
petr	unsit	m L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
68760, ificate be executed on physician and	as the burial-transit	Examiner	resulting in death) Last	Due to (or as a	consequence of	):				
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	filled in by the funeral director, page 2 should be detached for use as i	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetel death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of Month	delivery Day Year
ds, P.	ld be detai	d by Ph	Part II. Other significant conditions	contributing to death but	t not resulting in	the underlying cause gr	ven in Part I.			e to the cause of death?  Probably 4 Unknown
of Vital Records Physician: The law requires	age 2 shou	Completed						24a. Was an autopsy perform	ed? prior	
isn:	ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Death			
of V hysic	dire	To	1 ☐ Yes 🔑 No	Hospital: Inpatien			her: 4 Nursing Hom			pecify)
ing P	unera	iuo!	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Ti	jury Wo	ryat irk? ]Yes 2. □No	8d. Describe hov	v injury occurred	
Division of Vital I or Attending Physician: Director: Attentis sentifics	in by the f	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not determined	De Place of Injur		m, street, factory, office		8f. Location (Stre City or Town,		Rural Route Number,
To the Hospital o	etely filled	Medical Ce	29a. Certifier Check only one)	hysician: To the best of miner: On the basis of and manner stat	examination and	death occurred at the t /or investigation, in my	ime, date and place, a opinion, death occurre	nd due to the car d at the time, da	use(s) and manner te and place, and o	as stated. due to the cause(s)
o the	dmo	Me	29b. Signature and title of certifier				se number		d. Date signed (M	
	\		20 Name and Address of parent wh	completed cause of de						26, 2004
	V		30. Name and address of person who	ERSON W	of Un	CHTON	AUEOK	E RHI	LTIMORE	E MU
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1				
R	egistr	ar	0 4 2004	LENEW	10 16	parker				

State of Maryland / Department of Health and Mental Hygiene 2004

06732 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death Month 03 **Physician** eaNOR TRANCES 2004 7:00 AM 10 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ARY AND MUSONIC Homes If Under 1 Year If Under 24 Hrs. 8 Date of ocke Itimore 5. Social Security Number 8. Date of Birth Month, Day 6. Sex 7. Age (În yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1□ M 2X F Days O Yrs. 219-34-8005 Director PA Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours effer death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or Items 23s or 28s-f show 10a State 10c. City, Town or Location 10b. County r then "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐**X**No Director MD Baltimore Cockeysville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 300 International Circle 21030 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No ģ Specify: white 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Dietary Aide Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Otis Watson Helen Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an Item 27 is r r other treus Paula B. Clark/cousin 7704 Joe Johnson Rd., Newland, NC 28657 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State <u>=</u> 6 permit. Pege Depertment of Important: If any Injury or once. Donation 5 □ Other (Specify) Ft. Lincoln Cemetery 3/5/04 Brentwood, MD Signatura of Funeral Service Licenses 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. Bryan W. Clary 10 W. Padonia Rd., Timonium, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Cardio Vascular Disease Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner sician and buriel-transit or Attending Physicien: The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physician s the burie Physician/Medical Due to (or as e consequence of) ettending p ed by the e Part II. Other significent conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 Probably 4 Unknown 2 Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? page 2 s this certificate 1 🗆 Yes 2/2140 1 ☐ Yes 2 No director, Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3☐ DOA Medical Certification: To 1 Yes 2 No 28e. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No efter death 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital within 24 hours e To the Funerel D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely and manner stated. 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTU, My 21224 BAMA ST LIBG2TO, NO. Registrar's Signature State

Registrar

HYSICH	an	1. Decedent's Name (First, Middle,	Last)		Certifica			2. Date of D	Reg. No. Death Day	Year 04	3. Time of Death
/Medic	al	<u> </u>	Cpecca	Car		. Town or	Location of D		40.0	ounty of Death	
Examin	er	4a. Facility Name (If not institution,									
	No. of	515 Warren St. 5. Social Security Number 6		(In yrs. last birth		er 1 Year	-de-Gra If Under 24 i	Hrs. 8. Date of B	Birth	rford 9. Birth	nptace (State or Fore
ineral rector		212-22-6324	1□M 2ÅF		rs. Month	Days	Hours N	May 7	Day, Year)		untry) Land
		Usual Residence of Decedent		0.1				111017 1		11.042	
Mow M		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Lim
a - Ca	cto	MD HARFOR	D	HAV	RE-DE-	GRACE					1 ☐ Yes 2X☐
or 28	Directo	10e. Street and Number			10f. 2	ip Code			10g. Citize	on of What Co	untry?
23a	la	515 Warren St.				1078_				S.A.	
le ma	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Dec	edent of Hi ecify Cuba	ispanic Origin' n, Mexican, Pi	? (Specify Yes or fuerto Rican, etc.)	No- 14	<ol> <li>Race - Amer Black, White</li> </ol>	
rthan "natural", or items 23a or 28a-f show the Medical Exponer must be notified at	by Fi	1 Never Married 2 Marrier  3 Wildowed 4 Divorced	d 1 ☐ Yes 2 ☐XN If Yes, Give Year or Dates:	0	1 🗆 Yes	2 🗓 No	Specify:		5	Specify: B1	ack
E E		15. Decedent's		16a	Decedent's Us	ual Occupa	ation		16b. Kind	d of Business/I	
2	Completed	(Specify only highest	grade completed)		(Give kind of v	vork done d use retired	during most of	working	100111111		,
other than	mo	Elementary/Secondary (0-12) 7th	College (1-4or 5-		RSING	ASSIS'	TANT		NUI	RSING	
nt,	Č	17. Father's Name (First, Middle, La	ast)	1 212				Name (First, Midd			
D o	o Be	James Webster					France	es B. Mor	ık		
item 27 Is marked of other traumatic ev		19a. Informant's Name/Relationshi	p (Type, Print)	19b.	Mailing Addre	ss (Street a		r Rural Route Num		Town, State, Z	(ip Code)
27 ls		Jacqueline Jacks	on/Niece	661	Magno	lia C	t. Ber	nsalin, E	A 19	9020	
item		20a. Method of Disposition		20b. Place of cemeters	Disposition (A	ame of other place	<b>(a)</b>	Date	20c. Loca	ation - City or	Town, State
nt: H ry or		1 ☑ Burial 2 ☐ Cremation 3  1 ☑ Donation 5 ☐ Other (Spe		1	mes Ce			5-2004	Havre-	-De-Gra	ce, MD
Important: any injury once.		21. Signature of the state of t	centee		22. Name	and Addres	ss of Facility T	villiam (	. Brow	wn Comm	unity
any eny eny		1/1/9	rpeller		Funer	al Ho	me P.A	321 S.	Phila	. Blvd.	Aberdeer
hysician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of							T
attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	23c. If yes, outcome  1  Live birth  4  Pregnant at	2 Fetaf death	3 DEctopic				23	3d. Date of deli Month	very Day Year
	hys	9 Unknown	9□ Unknown								
by th	by	Part If. Other significant condition	ns contributing to death bu	it not resulting in	the underlying	g cause give	en in Part I.		Yes 2		the cause of death?
P 9	ole i							24a. Wh au pe 1 Yes	topsy rformed?	24b. Were au prior to death?	topsy findings availation of cause 2 No
as been sign 2 should be	Comp					1		Death (Check onl	y one		
as been sign 2 should be	Be Completed	25. Was case referred to medical examiner?	Hann't-1				er: 4 - Nurcu	ng Home 5 🗗 Re			cify)
is certificate has been sign director, page 2 should be	To Be	examiner? 1 Tes 2 No	Hospitaf: 1 fnpatie		patient 3			0016		occurred	
this certificate has been sign al director, page 2 should be	To Be	examiner? 1  Yes 2 No  27. Manner Death 1  Atural 5 Pending	28a. Date of fnjur (Month, Day		ime of	28c. Injun Work	y at k?	28d. Describ	e how injury		
Diractor: After this certificate has been sign in by the funeral director, page 2 should be	To Be	examiner? 1 \( \text{Yes}  2 \text{No} \) 27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. T	ime of hiury M	28c. Injun Work		28f. Location			ral Route Number,
Diractor: After this certificate has been s in by the funeral director, page 2 should	Certification: To Be	examiner  1 Yes 2 No  27. Manner Death  1 Natural 5 Pending investigate  3 Suicide 6 Could not determine  2 Accident 1 Could not determine	28a. Date of fnjur (Month, Day	y Year) 28b. T Ir Ir Ir Ir Ir Ir Ir Ir Ir Ir Ir Ir Ir	ime of hiury M rm, street, fact	28c. Injun Word 1 [] ory, office	y at k? Yes 2 □ No ne, date and p	28f. Location City or 1	(Street and Town, State)	Number or Ru	stated.
Diractor: After this certificate has been sign in by the funeral director, page 2 should be	To Be	examiner?  1 Yes 2 No  27. Manner & Death 1 Gratural 5 Pending investiga 2 Accident 3 Suicide 6 Could not determing  29a. Certifier (Check only 2 Medical E	ation of be 28e. Place of Injur (Month, Day building, etc.)  28e. Place of Injur building, etc.  3 Physician: To the best of xaminer: On the basis of	y Year) 28b. T Ir Ir Ir Ir Ir Ir Ir Ir Ir Ir Ir Ir Ir	me of M m, street, fact , death occurr.	28c. Injun Word 1 [] ory, office	y at k? Yes 2 No ne, date and p pinion, death o	28f. Location City or 1	(Street and Fown, State) ne cause(s) a e, date and p	Number or Ru	stated. to the cause(s)
uter this certificate has been sign ineral director, page 2 should be	edical Certification; To Be	examiner?  1	ation of be 28e. Place of Injur (Month, Day building, etc.)  28e. Place of Injur building, etc.  3 Physician: To the best of xaminer: On the basis of	y Year) 28b. T Ir Ir Ir Ir Ir Ir Ir Ir Ir Ir Ir Ir Ir	me of M m, street, fact , death occurr.	28c. Injury Word 1 [] ory, office	y at k? Yes 2 No ne, date and p pinion, death o	28f. Location City or 1	(Street and Fown, State) ne cause(s) a e, date and p	Number or Ru and manner as blace, and due	stated. to the cause(s)

State of Maryland / Department of Health and Mental Hygiene 2004 06734 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Evelyn February Irene Crum 2004 1:54 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Nursing Home Frederick Frederick If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 90 Yrs. 8. Date of Birth (Month, Day, Year) March 6, 1913 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number **Funeral** Months 1 ☐ M 2 🖫 F 220-10-5675 Yrs. Director Usual Residence of Decedent the Maryland permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or iteme 23s or 28s-1 show with jury or other treumatic event, the Madical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2200 Rosemont Avenue 21702 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Statue 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baitimore, Maryland 21215-0036 White Specify. 2 3∭Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aid Hospita1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edgar Gordon Null Bessie May Hiltner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1037 North Market Street, Frederick, MD 21701 Nancy J. Geisbert/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Olivet Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State March 1, 2004 Frederick, MD \*4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00021 Keeney and Basford Funeral Home ultura 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. proxima e Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) APRET Physician SEVERE SLEEP /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the buriel-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Year Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ HYPERTENSDON 1 Tyes 2 No 3 Probably 4 Unknown Completed COROMARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? PEGENERATIVE ARTHRESTS 1 🗀 Yes 2 MNo To the Hospital or Attending Physician: within 24 hours eiter death.
To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 70 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier D46075 8. Howellmo mare 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary P. Howell, M.D., 65-C Thomas Johnson Drive, Frederick, MD 21702 31. Date filed (Month, Day, Year) 32. Registrar's Signature State & Spertles ! MAR 0 4 2004 Registrar

	1 - For State Registrar		State of Ma	ryland / De <i>C</i>	partment of I e <i>rtificate of</i>	lealth <i>Death</i>	and Me	ntal Hy	giene Reg. No.		06735
Physician /Medical	1. Decedent's Name (Fin	^	ollins				1.	Date of De Month	Day	2004	3. Time of Death
Examiner Funeral Director	4a. Facility Name (If not a North WC).  5. Social Security Number 218-26-6105	St Hos	ipital	(In yrs. last birthda 74 Yrs.	4b. City, Town, Randall	If Unde	n Mur or 24 Hrs. 8.	Vland Date of Bio	rth ay, Year)	Co	
<u>D</u>	Usual Residence of Deco			10c. City, Town or	Location		1 2	,	172	7 110	10d. Inside City Limits
death with the Maryland ma 23a or 28e-f show result be notified at near a Director		Baltin Old Hand	over Road	Re	isterstow 10f. Zip Code 2	n 1136			-	izen of What Co	1 ☐ Yes 2 ☒ No untry?
JSO  Just after death v  Justine rung  Transfer rung  Transfer rung  Dy Funerai			12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		3. Was Decedent of If Yes, specify Cub	an, Mexica	an, Puerto Ric	y Yes or No can, etc.)	0-	14. Race - Ame Black, White Specify:	
DESILITIONE, INSTITUTION 2 12 15-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Important: If Item 27 is marked other than "natural", or Itema 23a or 28e-1 show any injury or other traumatic event, the Madical Examinat must be notified at an once.  To Be Completed by Funeral Director	15. (Specify or Elementary/Secondary 12	Decedent's Edu nly highest grad y (0-12)	ıcation	(Gi	cedent's Usual Occu ve kind of work done b. DO NOT use retire	durina mo	st of working			ind of Business/	Industry
yland A  yland be filed a  Mental Hygic  harked other hattc event, #	17. Father's Name (First,		Green	БС	is Driver		ner's Name (F	First, Middle	, Maiden		y Schools
E, Mary t and 2 sho tealth and 2 sm 27 is ma ther trauma	19a. Informant's Name/F Francis W. 20a. Method of Disposition	Collins		1310	oling Address (Street )8 01d Han position (Name of			Reis	ters	town, M	aryland
Sairimor	1 Burial 23 Cre 1 Donation 5   21. Signature of Funeral	emation 3 ☐ F Other (Specify)		Carroll	cremation  22. Name and Address	Ser.	3/3/0	)4	Hamp	stead,	Maryland
Dermi Departi Impo any in	23a. Part1. Enter the dis shock, or heart fail	sease, or compoure. List only o	ications that caused ne cause on each lin	the death. Do not e	LINE FUNE	RAL F	HOME Re	eister	stow		21136  Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	(	Due to (or as a	consequence of):	rhagge	************					Onset and Death 20 VIOUT
executed and rial-transit Examiner	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	iate <b>J</b>	c	consequence of):							
ate be sate be shysicial the burner of call		l	Due to (or as a	consequence of):							
COIGS, P.O. BOX of wrequires that the death certific been signed by the attending particuld be detached for use as letted by Physician/Mer	IF FEMALE: 23b. Was decedent pregint the past 12 mont 1 Yes 2 No 9 Unknown	grianit	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown	Fetal death	B Ectopic pregnanc	у			2	23d. Date of deli Month	very Day Year
wrequires that the been signed by th should be detache letted by Phys	Part II. Other significant	t conditions co	ntributing to death bu	t not resulting in the	underlying cause g	ven in Part	1.	23e. Did 1		1	the cause of death?
The lay ate has bage 2		medical				00 81-		1□ Yes	psy ormed? 22 No	prior to c death?	topsy findings available completion of cause of
ding Phys h. After this funeral di	examiner?		1 Inpatier 28a. Date of Injun (Month, Day	Year) 28b. Time Injury	of 28c. Inju	ner: 4 □ N	28d	5 Resi	dence 6 how injury	d Number or Ru	ral Route Number,
To the Hospital or Attention to the Hospital or Attention 24 hours after deal To the Funeral Director: completely filled in by the Medical Certifical		Certifying Phy Medical Exami	building, etc. sicien: To the best oner: On the basis of	f my knowledge, de examination and/or	ath occurred at the ti	me, date a	and place, and	City or To	Calleb(e)	and manner as	stated, to the cause(s)
To the within 2 To the complet	29b. Signature and title of		and manner stat	ed.	29c. Licens					e signed (Month	
10	30. Name and address of	Miche	180n +S	0 Main	e. Print) St Reister	stown	MD			'	
State Registrar DHMH 17 Rev 1/2001		0 4 20(	32. Registra	rs Signature	Span	2	* '				

DHMH 17 Rev 1/2001

			r per rn,	6037,09	Department of 109/04dhb	of Death			,2004	06730
hysician	Decedent's Name (F)  SYLVESTE		rte <i>e</i> z	OSNOWSK	т		2. Date of I	Da		3. Time of Death
/Medical Examiner	4a. Fecility Name (If not			CONOMOR		n, or Location of			26, 2004 County of Deat	<del> </del>
ammei	Johns Hopk	-				timore				
al or	5. Social Security Numb 213-52-086 Usual Residence of Dec	3 X	M 2□F 7. Ag	e (In yrs. last bii 【	Yrs. If Under 1 Ye Months Da		Min. 8. Date of E (Month, I	irth Day, Year) <b>0,194</b>	9. Birt Co <b>MD</b>	hplace (State or Forei untry)
tor		b. County N/A		10c. City, Tow	n or Location					10d. Inside City Limit
Director	10e. Street and Number	r			10f. Zip Cod	le		10g. Cit	tizen of What Co	ountry?
rai D	1126 News					1204			SA	
by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐	2 Married	<ol> <li>Was Decedent Armed Forces?</li> <li>1 ☐ Yes 2 ☐</li> <li>If Yes, Give Year or Dates:</li> </ol>		13. Was Decedent of If Yes, specify C		n? (Specify Yes or f Puerto Rican, etc.)	No-	14. Race - Ame Black, White Specify:	
Completed	15. (Specify of Elementary/Seconda	Decedent's Educ	completed)		. Decedent's Usual Oc (Give kind of work do life. DO NOT use re	ne during most o	of working	16b. K	(ind of Business/	Industry
Com	8th	ry (0-12)	College (1-4or 5	)+)	LABORE	R		C	ONSTRUC	LION
Be	17. Father's Name (Firs		·			18. Mother's	s Name (First, Midd	lle, Maiden	Sumame)	
2	SYLVESTER  19a. Informant's Name	CZOSNOW		106	. Mailing Address (Str	MARY	KURLINSI		or Town State 3	Zin Code)
		OSNOWSKI	_	20b, Place o	126 NEWCO	MB WAY,	BALTIMORI Date	E, MD		
	1 Burial 2 □ Ci	remation 3 🗆 Re	moval from State	cemete	ry, crematory or other deart of	place)	3/2/2004	3	timore,	
	21. Signature of Funera		θ							Eastern Av
	Jessic	ca Hogg	per DVR		Charles	S. Zeil	er & Son,	Inc	. 6224 I	Eastern Av
ner .	Immediate Cause (Finadisease or condition resulting in death)  Sequentially list condition and the cause. Enter Underlyin Cause, Disease or injur	( a.	Due to (or as	ic into	4.5					Onset and Death
dicai Examiner	cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last	C.	Due to (or as	a consequence	of):					
Physician/Medicai	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nths?	dc. If yes, outcome  1 Live birth  4 Pregnant at 9 Unknown	2 Fetal death	n 3 □Ectopic pregna 5 □ Other (specify				23d. Date of deli Month	ivery Day Year
by	Part II. Other significan	nt conditions conf	ributing to death b	ut not resulting i	n the underlying cause	given in Part I.		tobacco i		the cause of death?
Completed								opsy formed?	prior to death?	topsy findings availab completion of cause of 2 \square No
Be	25. Was case referred examiner?		ospital:			Othor	f Death (Check only			
. To	1  Yes 2 No 27. Manner of Death	110	i <b>X</b> _1 inpatie		Time of 28c. In	Other: 4 \(\text{\backsq}\) Nurs	ing Home 5 ☐ Re 28d. Describe			cify)
ation		Pending investigation	28a. Date of Inju (Month, Da) 2-25-04	y Year) UN	Injury \	Work? I∐Yes 2.⊠No				
Ö		Could not be determined	28e. Place of Injuding, etc		arm, street, factory, offi	Се	28f. Location City or T	(Street ar	nd Number or Ru	ral Route Number,
Ξ			3,	unknov			unkn		-/	
Certification:		1	ician: To the best	of my knowledge	e, death occurred at the	e time, date and	place, and due to th	e cause(s)	and manner as	stated.
Medical Certifi	29a. Certifier 1 (Check only one)	Medical Examin	er: On the basis of and manner sta	examination an	nd/or investigation, in m	ny opinion, death	occurred at the time	e, date and	d place, and due	to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 001 Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 3:41pM 2004 COBBS February 29 SALLY PEARL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 305 ROXBURY COURT

5. Social Security Number 6. Sex JOPPATOWN

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. (Month, Day, Year) HARFORD CO Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X Director 74 March 3 1929 W. VIRGINIA 097-24-1099 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or iteme 23s or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Directo MARYLAND HARFORD CO HARFORD CO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 ROXBURY COURT 21085 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: If Yes, Give Year or Dates: Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filed within 7 al Hyglene. College (1-4or 5+) Elementary/Secondary (0-12) REGISTERED NURSE HEALTH CARE 12yrs 4yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 end 2 should be fil frient of Health and Mental H tent: if Item 27 is marked otl jury or other traumatic ever Be 2 BESSIE ARNOLD unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Roxbury Ct., Joppatown, Maryland 21085
e of Disposition (Name of Date 20c. Location City or Town, State Jacob E. Cobbs/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: if any Injury or once. A □ Donation 5 □ Other (Specify) METRO CREMATORY 03-03-04 BALTIMORE MARYLAND 21. Signature of Finaral Sen 22. Name and Address of Facility WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancel 6 years Physician in /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physician and for use es the buriel-transit The law requires that the deeth certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 No 9 ☐ Unknown ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an hes autopsy performed? 1□ Yes 2√2No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No this 28c. Injury al Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation 1 Natural 2 Accident after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 ho To the Fune completely fi (Check only one) and manner stated. 29c. License number 29d. Date, signed (Month, Day, Year) 29b. Signature and title of certifier M 1848 04

State Registrar

m

m 40

31. Date filed (Month, Day, Year)

THANT

MAR 0 4 2004

32 Registrar's Signature

& 114 SANDPIPER CIRCLE, BALTO, MD 21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 200406738 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** MAR. 2004 EDWARD LEE DAVIS 12:10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A FUTURE CARE FACILITY HOMEWOOD BALTIM) RE
If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Min. 1₹M 2□F Months 71 NOV.14,1932 North Caroli Director 245 42 7610 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23s or 28a-f show shy injury or other traumatic event, the Medical Example or other traumatic event. 10a State 10b. County 1 Yes 2 No MD. N/A BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4542 PIMLICO ROAD 21215 U.S. OF A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 Xio If Yes, Give Year or Dates: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BALTO. GAS & ELEC. 11TH GRADE UNKNOWN FORMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN DAVIS (DECEASED) TINNY MORROW ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9a. Informant's Name/Relationship (Type, Print) VIRGINIA RUTH DAVIS (WIFE) 4542 PIMLICO ROAD BALTO., MD. 21215 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PARK 3/6/04 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fineral Service Licensee S T. GWYNN

Lewis S Lwymw LEWIS T. GWYNN FUNERAL HOME 21215-6393 HEIGHTS AVENUE BALTO , MP proximate 4517 PARK 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Kene **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner enphal an Samentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit death certificate be executed Ster Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Year in the past 12 months? Month Dav 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 Yes 2 No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. page 2 should be 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 1 No 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after deal To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 \ Homicide 1C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and marrier as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sute 208 38 SHM Day Dan 2004 Saste 31. Date filed (Month State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 06739 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 28, 5:45p™ FEB. LINDA M. DELANEY /Medical 4c. County of Death 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CATONSVILLE BALTIMORE 920 SOUTHRIDGE ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/23/48 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days PENNSYLVANIA 1 □ M 2 🖫 F 55 Yrs. 214-50-5841 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a, State 10b. County r than "naturel", or Itams 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director GARRETT OAKLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number P.O. BOX 2336 21550 USA STEYER MINE RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 M Married 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY BAIL BONDS 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be JAMES MANEY LILLIAN HAUSELE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 5 5 () 19a. Informant's Name/Relationship (Type, Print) TERRY DELANEY /HUSBAND STEYER MINE RD. P.O. BOX 2336 OAKLAND, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State CEDAR HILL CEME. 3/3/04 BROOKLYN PARK, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenste RACZOROWSKICHTUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 23a. Part 1. Enter the disease, or confdications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Squemous Carcinama the SHUS Huguths **Physician** /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced to the control of Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Pol 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an autopsy page performed? 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother Specific T.C.T. Hospital: 1 ☐ Inpatient 1 Tyes P 2 No 3 DOA 2 ER/Outpatient RESIDENCE 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 \ Homicide within 24 hours a 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number DIRECTOR, 023675 Merch 1, 2004 MEDICAL DNCOLOGY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beltruone, MO 21231 Johns Hophins Causer Center ROSS C. DONE HOWER, WID 31. Date filed (Month Per Yfar) 4 2004 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

of Vital Records, P.O. Box 68760,

Division

State of Maryland / Department of Health and Mental Hygiene 2004 06740 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2, 2004 4:30PM March John William Dooley, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5900 Queen Anne Street Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, MAR 9, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 12M 20F 81 Yrs. 214-16-7267 Kentucky Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other than "natural", or items 23a or 28a-f show 1 Yes 2 No Directo Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 5900 Queen Anne Street USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Xes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify White 3 ☑ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Federal Reserve Bank 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Important; if item 27 is marked o 2 Moses Dooley Martha Sears and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5900 Queen Anne Street Baltimore, MD 21207 Doris M. Parton/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 20a. Memod of Disposition

1 Burial 2VI Cremation 3 Removal from State

4 Donation 5 Other (Specify)

21. Signature of Fuseral Service Licensee

Fdward A. Cregorchik ö Metro Crematory Inc. 3-3-04 Baltimore, MD 23. Name and Address of Society of MD 299 Frederick Road bal any in Inc. Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) monea **Physician** how /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit the attending physicien and Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day ō Month Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by **pe** 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1☐Yes 2☑No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Indus 15 V March 3, 2004 n Little Parkerst Pleny Coloniams 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 4 2004 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 200 L 06741 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** JACQUELYN V. CEASER EVANS 10:31 AM February 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Hassital Ballimore Sinai If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 217-68-0491 50 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 ie marked other then "naturel", or items 23s or 28a-f ehow traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Baltimore Maryland N/A Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 2436 Callow Ave. 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 le marked other then "naturel", or ite 1 ☐ Never Mamed 2 ☐ Married 1 ☐ Yes 2 ☐ XNo Specify: 5-0036 Specify Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 2121 Philip's Crab House Elementary/Secondary (0-12) College (1-4or 5+) Cook 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland Be Mildred Hope Ceaser Leo Katon Ceaser 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 le eny injury or other trau once. LaShawn Blake 2436 Callow Ave. Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/05/04 Reisterstown, Md. St. Lukes Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funetal Service Licensee Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 Part . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mening I oma

Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Deficiency Syndrone Sequentially list conditions, if any, leading to immediate cause. Ener underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (0) as a consequence of): Examiner death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical as the the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown ģ peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 200 3 ☐ Probably 4 ☑ Unknown 1 Tyes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed2 certificate 2 No 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funaral Direct 4 🗌 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and titte of certifier 29c. License number February 27, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belordere Ave Baltimore, 2401 West M.B. ALI MAHAJARIN 32. Registrar's Signature State The State of Registrar

DHMH 17 Rev 1/2001

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1			State of Maryland / Dep State of Maryland / Dep Per ME,G829,03/04/04/04/04/04/04/04/04/04/04/04/04/04/	artment of Health and I Artificate of Death	Mental Hygien Reg. N		5742 e of Death
7	Physici		Patrick D. Fowler Sr.			ay Year 29, 2004 8:0	2 7 M
	/Medio		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	Z_A
			Upper Chesapeake Medical Center	Bel Air		Harford	
v	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 81 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	(Month, Day, Yea	9. Birthplace (Sta Country) 922 West Vir	
	land ow		10a. State 10b. County 10c. City, Town or L	ocation		10d. Insid	e City Limits
	Mary I-f sh	tor	Maryland Baltimore Middle	River		1 🗇 1	Yes 2⊠No
	or 284	)irec	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?	
	death with the Maryland ims 23a or 28a-f show ritheat be confilled at	rai	2121 Hawthorne Rd.	21220		USA	
036	be filed within 72 hours after death with the Marylan nat Hygiene. ed other than "natural", or flems 23a or 28a-f show event, I've Medical Exant art must be collited at	by Funeral Directo	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ♣ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indiar Black, White, etc. Specify: White	٦,
21215-0036	within 72 ho ene. than "natur te Medicel	Completed	(Specify only highest grade completed)  (Giv  Elementary/Secondary (0·12)  College (1·4or 5+)	edent's Usual Occupation a kind of work done during most of wor DO NOT use retired)	rking	Kind of Business/Industry	
7	e filed v il Hygie other t vent, th		12 M	achinist	AE me (First, Middle, Maide	ero Space	
and	ould be f Mental thanked of	To Be	Winters Jennings	Margare		Joinaine,	
Maryland	S D E E	ř		ing Address (Street and Number or Ru		or Town, State, Zip Code)	
ž	and 2 alth a 127 is		Dorothy H. Fowler (Wife) 2121	Hawthorne Rd. Ba	ltimore, Mo	l. 21220	
ore	of He of He fitem r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, cre	osition (Name of ematory or other place)	Date 20c.	Location - City or Town, State	9
Ĕ	Pag ment ant: I			11 Mem.Gardens 3/3	3/2004 Bal	timore, Maryl	and
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or othar ti once.	Į.		2. Name and Address of Facility Bruzdzinski Funer 1407 Old Fastern	Avenue Esse	x, Md. 21221	
8760,	Physician / Medical Examiner and physician and physician and the primaritansit	ıi Examiner	Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	usies			Between nd Death
Box 6	ne death certific the attending p thed for use as	Physician/Medicai		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year
rds, P.O.	res tha igned be del	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause 2 7 Probably 4	of death?
I Records,	The ate h	Completed		A.	24a. Was an autopsy performed?	24b. Were autopsy findin prior to completion death? 1 Kes 2 No	
Vital	sicien: Certifica rector, p	Be	25. Was case reterred to medical examiner?	0.1	ath (Check only one)		
of	90 1	. To	1 X Yes 2 □ No Hospital: 1 □ Inpatient 2 X ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time		lome 5 Residence		- (2
Division	or Attending ifter death. Diractor: After in by the fune	Certification:	1 Natural 5 Pending investigation 2 Accident 5 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	5 M 1□Yes 2×No	28f. Location (Street a City or Town, Sta	ACCIDENTWITH	Police Vehich
	To the Hospital within 24 hours a Yo the Funeral I completely filled	edical	29a. Certifier (Check only one)  1□ Certifying Physician: To the best of my knowledge, dea  2√ Medicel Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place investigation, in my opinion, death occu	and due to the cause(	s) and manner as stated.	
•	Y Y Y Y Y COMP	W	29b. Signature and title of certifier Pollow M	29c. License number  O.C.M.E.		ate signed (Month, Day, Yea Ch 01, 2004	r)
	5		30 Name and address of person who completed cause of death (Item 23a) (Type	, Print)  1 Penn Street, Ba	ltimore, Ma	ryland 21201	
	Sta		31. Date filed (Mcky Aray, Year) 2004 32. Registrar's Signature	Land .			

Regina Fitzgerald 04-01560 RJ 1- 500

Physician /Medical Examiner  Baltimore, Maryland 2712-560  Baltimore, Maryland 2712-560  Funeral Director  Director  Director  Second Second 2712-560  Usual Resident 10a, State Maryland	nion Avenue rity Number 6. S. 1-9300 1 ce of Decedent 10b. County and N/A d Number nion Avenue tus Married 2 Married red X Divorced 15. Decedent's Ed Specify only highest gra Secondary (0-12) Ame (First, Middle, Last) Parsons t's Name/Relationship (1) Banks	Apartment  Apartment  Apartment  Apartment  Apartment  Apartment  Apartment  Apartment  Apartment  Amed Forces?  I \( \text{Yes} \) Give  Year or Dates:  ducation  ade completed)  College (1-4or 5+)  Type, Print)	(In yrs. last birthda)  54 Yrs.  10c. City, Town or I  Ba1  nt A  ver in U.S. 13  ) 16a. Dec (Giv life. Be	If Under 1 \ Months   D    Location  Location  Limore  10f. Zip Co  Was Deceden If Yes, specify  1   Yes XX  Redent's Usual Co  Po kind of work of DO NOT use in	ode 21211 t of Hispanic Origin? (Cuban, Mexican, Pue) I No Specify: Occupation fone during most of wellred) In/Hairdres	8. Date of Bir (Month, Da May 4, May	Day Y 2004  1, 2004  4c. County of N/ N/ 1949  10g. Citizen of Wh.  USA  14. Race - Black, Specify:  16b. Kind of Busin	A D. Birthplace (State or Foreign Country)  Maryland  10d. Inside City Limits  XXYes 2 No at Country?  A  American Indian, White, etc.  white ness/Industry
Battimore  Battimore  1432 U  5. Social Security  212-56  Usual Resident  10a. State  Marylad  10a. Street and  11. Marital Sta  10 e Street and  11. Marital Sta  11. Marital Sta  11. Marital Sta  11. Marital Sta  12. Signature  13. Widow  14. Elementary/  8. Robert  14. Elementary/  8. Robert  19a. Informant  19a. Informant  19a. Informant  19a. Informant  19a. Informant  20a. Method o  1 Burial  1. Signature  21. Signature  22a. At 1. Elementary/  2a. Method o  1 Burial  1. Signature  2a. Method o  1 Burial  2a. Method o	nion Avenue  inty Number 6. Si 1-9300 1  ce of Decedent 10b. County  Ind N/A  d Number 10 Avenue  tus  Married 2 Married  red X Divorced 15. Decedent's Ed  Secondary (0-12) 2  ame (First, Middle, Last)  Parsons  t's Name/Relationship (1)  Banks  f Disposition 3 Dither (Specify Signature)  tion 5 Other (Specify Signature)	Apartment  Apartment  7. Age  Apartment  12. Was Decedent Evamed Forces?  1  Yes Stip No If Yes, Give Year or Dates:  ducation  College (1-4or 5+)  Type, Print)	(In yrs. last birthda)  54 Yrs.  10c. City, Town or I  Ba1  nt A  ver in U.S. 13  ) 16a. Dec (Giv life. Be	If Under 1 \ Months   D    Location  Location  Limore  10f. Zip Co  Was Deceden If Yes, specify  1   Yes XX  Redent's Usual Co  Po kind of work of DO NOT use in	daltimore fear If Under 24 Hr. lays Hours Mir  bode 21211 t of Hispanic Origin? ( Cuban, Mexican, Pue i) No Specify: Decupation fone during most of we retired) In/Hairdres	8. Date of Bir (Month, Da May 4, May	10g. Citizen of Wh.  USA  14. Race - Black, Specify:  16b. Kind of Busin	Death  A  Birthplace (State or Foreign Country)  Aryland  10d. Inside City Limits  XXYes 2 No at Country?  A  American Indian, White, etc.  white ness/Industry
Baltimore, Maryland 21212-0036  Baltimore, Maryland 21212-0036  Baltimore, Maryland 221212-0036  Baltimore, Maryland 10a Street and 10a Stree	ce of Decedent 10b. County 10c. County 11c. County 11c	Apartme  Apartme  Apartme  12. Was Decedent Ev Amed Forces? 1 Ses Sive Year or Dates: ducation ade completed)  College (1-4or 5+)  Type, Print)  Removal from State	(In yrs. last birthda)  54 Yrs.  10c. City, Town or I  Ba1  nt A  ver in U.S. 13  ) 16a. Dec (Giv life. Be	If Under 1 Months D  Location  Location  Limore  10f. Zip Co  Was Deceden If Yes, specify  1 Yes XX  Gedent's Usual Co  Ye kind of work of  DO NOT use in	rear If Under 24 Hr. In If Under	May 4, Specify Yes or Norto Rican, etc.)	10g. Citizen of Wh.  10g. Citizen of Wh.  USA  14. Race - Black, Specify:  16b. Kind of Busin	D. Birthplace (State or Foreign Country)  Maryland  10d. Inside City Limits  XX Yes 2 No at Country?  A  American Indian, White, etc.  white ness/Industry
Director  Director  Director  Director  Director  Debatiment of Maryland 10a. Street and 10a.	ce of Decedent  10b. County  10b. County  10b. County  10b. County  10b. County  N/A  d Number  Inion Avenue  15. Decedent's Ed  Specify only highest gra  Secondary (0-12)  Parsons  It's Name/Relationship (1  Banks  If Disposition  XXI Cremation 3 □  tion 5 □ Other (Specify	Apartmen  12. Was Decedent Even Armed Forces? 1	54 Yrs.  10c. City, Town or I  Ball  nt A  ver in U.S. 13  16a. Dec  (Giv. life. Be	Months D  Location  Limore  10f. Zip Co  Was Deceden If Yes, specify  1 Yes XX  Gedent's Usual Co  We kind of work of DO NOT user	ode  21211  t of Hispanic Origin? ( Cuban, Mexican, Pue  ] No Specify:  Occupation tone during most of we etired)  n/Hairdres	May 4, Specify Yes or Norto Rican, etc.)	1949 N  10g. Citizen of Whi  USA  14. Race - Black, Specify:  16b. Kind of Busin  Hairdre	Aryland  10d. Inside City Limits  XX Yes 2 No at Country?  A  American Indian, White, etc.  white ness/Industry
Nelson  Nelson  20a. Method o  1 Buriat  4 Donat  21. Signature  23. 11. Er shock, o  1. Signature  24. Signature  25. Signature  26. Signature  27. Signature  28. Signature  29. Signature  20. Signature  20. Signature  20. Signature  21. Signature  22. Signature  23. Signature  24. Signature  25. Signature  26. Signature  26. Signature  27. Signature  28. Signature  29. Signature  20. Signatu	Ind N/A  Inion Avenue  Itius  Married 2 Married  Specify only highest gra  Secondary (0-12)  Ame (First, Middle, Last)  Parsons  It's Name/Relationship (1)  Banks  If Disposition  Married 2 Married  Married 2 Married  Married 2 Married  Married 15. Decedent's Ed.  Specify only highest gra  Secondary (0-12)  Married 15. Decedent's Ed.  Married 2 Married  Married 2 Married  Married 2 Married  Married 15. Decedent's Ed.  Married 2 Married  Married 2	Apartmen  12. Was Decedent Ev Armed Forces?  1	Ball  nt A  ver in U.S.   13  16a. Dec  (Giv  life. Be	10f. Zip Co	21211 t of Hispanic Origin? (Cuban, Mexican, Puell In Specify:  Occupation fone during most of well red)  n/Hairdres	nto Rican, etc.)  orking  SET	USA  14. Race - Black, Specify:  16b. Kind of Busin	XXYes 2□No at Country? A American Indian, White, etc. white
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Nelson  Nelson  20a. Method o  1	Parsons It's Name/Relationship (1) Banks If Disposition In XIX Cremation 3 — Ition 5 — Other (Specific	Type, Print)			18. Mother's Na	me (First Middle		essing
Nelson  Nelson  One see and se	Banks  f Disposition  XXCremation 3 □  tion 5 □ Other (Specific	Removal from State			Unknow		Maiden Sumame)	
Department of the property of	f Disposition    XX Cremation 3 □ tion 5 □ Other (Specify		1/22		treet and Number or F			
Baltimore of minimum and minim	tion 5 Other (Specify		20b. Place of Disp cemetery, cri	Union (Name	Avenue Apt	. A Bal	timore, M. 20c. Location - Cit	
Physician // / / / / / / / / / / / / / / / / /	of Financi Connect in	<i>(y)</i>	1		ngton : 3/5	/04	Laurol	Maryland
Physician / Medical Examiner  Page 10	or izritiatisti Satolca/C109U	nse /	Crema	Out of and A	Address of Facility Henss-Seit			
Sequentially life any leading cause. Enter Cause interest that initiated e resulting in de resulting in de	ndition	Narcotic a.	he death. Do not e	3631 Fa	11s Road f dying, such as cardia	Raltimo c or respiratory a	re, Maryl	And 21211 Approximate Interval Between Onset and Death
a pricis	vents	с.	сипрационен об):					
Box 6 Beath certification of the beath certification of the base o		_ d	consequence of):					
P.O.  The definition of the state of the sta	st 12 months?	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregr			23d. Date of Month	*
d by Digital Part II. Others	significant conditions o	contributing to death but	not resulting in the	underlying caus	se given in Part I.			ute to the cause of death?
Olivision of Vital Records, for Attending Physicien: The law requires affect death.  Director: After this certificate has been sign in by the funeral director, page 2 should be ertification: To Be Completed by ertification: To Be Completed by House Services.	referred to medical					Yes	prio prio dea 2 No 1	re autopsy findings available in to completion of cause of the cause o
25. Was case examiner?		Hospital: 1 ☐ Inpatient	t 2 ER/Outpatio	ent 3 DOA	Othor	ath (Check only a	tence 6 Other	(Specify) Scene
T 27. Manner of		28a. Date of Injury (Month, Day		of 28c.	Injury at Work?		now injury occurred	
Single Si	ent investigation	3/1/04	unknow	n M	1 ☐ Yes 2x No	unknown		
Division  To the Hospital or Attending Father Hospital or Attending Father Hospital or Attending Father Hospital or Attending Father Hospital Order (1997)  Medical Certification:  Medical Certification:  7. Wanuer of Complete Hospital Order (1997)  8. Wanuer of Complete Hospital Order (1997)  9. Wanuer of Complete Hospital Order (1997	dataminad	building, etc.		street, factory, of	ffice	City or Tox	vn. State)	or Rural Route Number, Baltimore, MD
The Control of the Fundamental o	1 Certifying Ph 2 Medical Exan	nysician: To the best of miner: On the basis of e and manner state	examination and/or i	ath occurred at t investigation, in	he time, date and place my opinion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	er as stated. If due to the cause(s)
29b. Signardre	and title of certifier	emp			cense number		29d. Date signed (A March 2,	
30. Name and		completed cause of dea	ath (Item 23a) (Type	e. Print 111	Penn Stree	t, Baltir	nore, Mar	yland 21201

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

For State State RegistramEND ITEM #20b PFR FH G829 3/04/04 Sertificate of Death

1. Decedent's Name (First, Middle, Last)

JOSEPH

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

4b. City, Town, or Location of Death

2. Date of Death

-Month

Day 3 2000

4c. County of Death

06745

3:05 AM

3. Time of Death

		*	NORTHWEST HOSPI	TAL 5401 OLD	COURT RD		RAND	ALLSTOWN		BALTI	IMORE	
400	Funeral Director		5. Social Security Number 215-30-5803	6. Sex 7 1	. Age (In yrs. Ia 69	st birthday) Yrs.	If Under 1 Year Months Days			irth ay, Year) 934	Birthplace (State or Foreign Country)     MARYLAND	
	pu »		Usual Residence of Decedent  10a. State 10b. County		100 City	Town or Lo					101 1-11 01-11	
a-f shor		Director	MARYLAND TOO. COUNTY			LTIMORE					10d. Inside City Limits 1 ☐ Yes 🌣 No	
	th the	ire	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country?	
	th will	aic	4800 SETON DRIVE				2	1215		U.S.A.		
	r dea	ner	11. Marital Status	12. Was Deced Armed Ford		13.	Was Decedent of I	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or N	o- 14. Ra	ce - American Indian,	
Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, the Modical East offer must be ricitified at once.		by Funeral	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 🖾 🛱 ivorced	ed 1 Tes X	1 Yes XX No If Yes, Give Year or Dates:		1 Yes 2 No Specify:			Black, White, etc.  Specify: WHITE		
2	72 ho	etec	15. Decedent	s Education		16a. Deced	dent's Usual Occup	pation during most of wo	ndeina	16b. Kind of E	Business/Industry	
Maryland 21215-0036	d within giene. er then "	Completed	Elementary/Secondary (0-12)	College (1-4	4or 5+)	life.	DO NOT use retire LABOR	od)	g	MET	AL	
g	e file othe vent,	Be C	17. Father's Name (First, Middle,	ast)				18. Mother's Na	me (First, Middle	, Maiden Suma	me)	
<u>0</u>	Alenta Alenta rked tlc a	ToE	UNK					CATHERII	NE PELTZ			
ary	short Name		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (Street	and Number or R	ural Route Numb	per, City or Town	n, State, Zip Code)	
	elth a		LORI D. HARDEN	DAUGHTER		361	2 RED ROSE	FARM CHASI	E. MD 2122	.0		
Je,	of He item		20a. Method of Disposition			ce of Dispo	sition (Name of natory or other pla		Date	T	- City or Town, State	
Ĕ	Pege nat: M		1 ☐ Burial 2 XXCremation  4 ☐ Donation 5 ☐ Other (Sp		ate		EMATORY IN	2/20/	04 <del>)4022</del> 6	BALTIMO	RF. MD	
Baltimore,	permit. Departm Importe any inju		21. Signature of Funeral Service I	11.	M01148	FI	Name and Addre	HOME, P.A.	•		N2, 110	
			23a. Part 1 Enter the disease, or shock or heart failure. List			Do not ent	er the mode of dyi	Y SW CLEN I ng, such as cardia	c or respiratory	21061 arrest,	Approximate	
) #	Physician		shock/or heart tailure. Lish Immediate Cause (Final disease or condition resulting in death)	aa	ch line. SE		ic S			_	Interval Between Onset and Death	
	/Medical Examiner		, and the same of	Due to (o.	rasa consequ		05 / 1 44				WEEKI	
		-	Sequentially list conditions, if any, leading to immediate	b. Due to to	r as a consequ		NIA.				7,00,0	
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	, a a a a	. 45 4 55.15545	31100 51).						
_	xecu and	хаг	that initiated events resulting in death) Last	c Due to (o	C							
9	sicier buri	ai										
687	ficate p physics the	edic		d		-						
ds, P.O. Box 68760,	uires that the death certificate be executed signed by the attending physicien and Id be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 5 No 9 □ Unknown		th 2 Fetal of de	death 3□	Ectopic pregnanc Other (specify)	у			ate of delivery onth Day Year	
<u>ď</u>	hat the	P.	Part II. Other significant condition	ns contributing to dea	th but not recul	ting in the u	adorhijaa causa su	uon in Dart I	22e Did	tobacco uso con	ntribute to the cause of death?	
	quires t	0	CARDIOM70Pr	HAY, AT	21172	FIBR	icution i				3 □ Probably 4 ◯ Unknown	
Recor	Complete	PREVIOUS CE	REBROWN	SCENAR	DISCH	りに				Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No		
ita	ien: rtifica stor, I	Be	25. Was case referred to medical					26. Place of De	ath (Check only		12.100 22.10	
<b>&gt;</b>	nysic als ce direc	ToE	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1×Inj							her (Specify)	
Division of Vital	nding Pł th. :: Alter the funeral		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investig		Injury , Day Year)	28b. Time of Injury	Wo			how injury occur		
Divis	after des Olrecto	Certification;	3 Suicide 6 Could r 4 Homicide determ	ned 200. Place o	f Injury - At hor g, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location City or To	(Street and Num. iwn, State)	ber or Rural Route Number,	
	To the Hospitel or Attending Physicien: The law requivilin 24 hours after death.  To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should be a suppletely filled in by the funeral director, page 2 should be a suppletely filled in by the funeral director.	Medical C	29a. Certifier  (Check only one)  1 Certifyin 2 Medical	g Physician: To the b Examiner: On the bas and manne	sis of examinati	rledge, death on and/or in	n occurred at the two	me, date and place	e, and due to the urred at the time	cause(s) and m , date and place,	nanner as stated. , and due to the cause(s)	
	orthin orthin ompl	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signe	ed (Month, Day, Year)	
	<b>∆</b>		> Klanja	rapu	MD		D5	4288		Februa	14 23×12004	
	11)		30 Name and address of person	who completed cause	of death (Itam	23a) (Type	Print\			,		

DHMH 17 Rev 1/2001

State

Registrar

XAMITININY 31. Date filed (Month, Day, Year)

MAR 0 4 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - HOSPINA CEMEN LANGARAM, INDIVIDUAL HOSPINA CEMEN

		-	State of Maryland / De	epartment of Health and Certificate of Death	Mental Hygier	ne2004 06746
			Decedent's Name (First, Middle, Last)		2, Date of Death Month	3. Time of Death
	Physicia		Joyce Ann	Fidler		27, 2004 10:22 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death
			Harbor Hospital Center	Baltimore		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Davs Hours Mir		9. Birthplace (State or Foreign Country)
	Director		220-30-6508 1□M 2\RF 69 YI	S	Uct 19, 1	1934 " MD
	pu *	1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	sho	5		Burnie		1 ☐ Yes 2 ☐ No
	28a-1	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	with			21061		U.S.A.
	within 72 hours after death with the Maryland one. Then "netural", or Itams 23a or 28a-f show he Medical Exacilinar must be notified at	Funeral	11.6 Shelly Road  11. Marital Status  12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - American Indian,
	ter d	Fu	1 Never Married 2 Marned 1 Yes 2 No	If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	Black, White, etc.
2-003p	urs a	by	3 Widowed 4 □ Divorced If Yes, Give X Year or Dates:	1 ☐ Yes 21 No Specify:		Specify: White
2	72 ho	ted	15. Decedent's Education 16a. [ (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of w	orking 16b	. Kind of Business/Industry
N	thin 7	nple	Elementary/Secondary (0-12)   College (1-4or 5+)	Give kind of work done during most of wi life. DO NOT use retired)		
7	ygien ygien war th	Completed		okkeeper	ame (First, Middle, Maid	Home Improvement
and	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene.  Is marked other then "netural", or Itams 23a or 28a-f show atmatic event, it a Medical Exacilities marked.	Be	17. Father's Name (First, Middle, Last)			en Sumame)
<u>X</u>	should nd Men marke umatic	ို	Howard Babylon		Babylon	the Town State Zin Code)
Mar	2 sh and Is m			Mailing Address (Street and Number or F		The state of the s
	ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic			009 Walnut Avenue		MD 21206 Location - City or Town, State
0	Pages I nent of H int: If ite iry or ot		1 Burial 2 Vicremation 3 Hemoval from State		rch 3	
Saltimore	tmen tant:					cevensville, MD
a C	permil. Pages 1 Department of H Important: If ite eny Injury or ott		21. Signature of Furreral Service Licenses	22. Name and Address of Facility	ingleton Fu	ineral Home, P.A.
			23a. Fart1. Enter the disease, or complications that caused the death. Do no	1 Second Avenue,		Approximate
			shock, or heart failure. List only one cause in each line.  Immediate Cause (Finat	/		Interval Between Onset an Death
	Physician /Medical		disease or condition resulting in death)  Due to (or as a constitution in the constitu	ry Embol	us	2 hours
8760,	death certificate be executed as e attending physicien and in for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a cinsequence of content of the content of	al Vascu	lar Di	sease 20 years
O. Box 68	he death certifica the attending ph ched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Vo 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
ds, P.	The law requires that the de ste has been signed by the a bage 2 should be detached b	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		Se contribute to the cause of death?
Record	w require been sig should b	ete			24a. Was an	24b. Were autopsy findings available
ž	has ge 2	mp			autopsy performed	prior to completion of cause of death?
ä			oc W.	00.01	1 Yes 2	Ne 1 Yes 2 No
Vita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?  1   Yes   2   No	Other	eath (Check only one)	a Compani (Spanis)
	Attending Physician: It death. ector: After this certific by the funeral director,	tlon: To	27. Mann of Death 28a. Date of Injury 28b. Ti		Home 5 Residence 28d. Describe how i	
Division of	of or Attending I safter death. I Director: After d in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	π, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and pla /or investigation, in my opinion, death oc	ce, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the H within 24 To the F complete	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			Lovolo Unoffen	M) D378	14	ebruary 27, 2004
	1-		30. Name and address of person who completed cause of death (Item 23a) (	Type, Print) 3 (	001 5047	Ly Hanquer Stree
	4		Gesald Hoollon M	iD: Harbor	Hospita	1 center
-	St Regist	ate trar	31. Date filed (Month, Day, Year)  MAR 0 4 2004	ande	1	

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 11- State Amend Item 19b per FH,G829,03/04/04dbbertificate of Death

Reg. No. 06747 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2<u>004</u> **Physician** MARCH 1, 7:45 FOREMAN MOLLIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE BALTIMORE MILFORD MANOR NURSING HOME If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 X APRIL 15,1914 NEW YORK 89 168-30-1112 Director Usual Residence of Decedent 10c. City, Town or Location BALTIMORE 10d. Inside City Limits the Maryland 10a. State MD 10b. County 28a-f ehow Examiner must be notified at BALTIMORE 1 Yes 2 No Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number items 23a or 4204 OLD MILFORD MILL ROAD 21208 USA death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or then eny injury or other traumatic event, the Modiful Examiner ODGE. 1 Never Married 2 Married WHITE 1 Yes 2 No Baltimore, Maryland 21215-0036 δ 3 ₩idowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be OXENBERG MARION SOLOWAY WILLIAM 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 SAXONY CT 19a. Informant's Name/Relationship (Type, Print) ER 3 SOXONY COURT, 20b. Place of Disposition (Name of BETH O') ACCOMP CONG. PIKESVILLE, MD 21208 /\_DAUGHTER JUDY ZERWITZ 20a. Method of Disposition MAR.3,2004 FINKSBURG, MARYLAND 1 X Burial 2 Cremation 3 Removal from State 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses Edwara 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition PARKINBONS and mone Enysician a. ENO STAGE resulting in death) /Medical Examiner Sequentially list conditions, Due to (or as a consequence of) Physician/Medical Examiner if a y localing to immedia cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760( as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?

1 Yes 2 No
9 Unknown Month Day jo 4☐Pregnant at time of death 5 Other (specify) should be detached P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check onl. one Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 2. 2004 PAKIC HEIGHTS AVE BALTIMONE MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLGVCE 7220 31. Date filed (Month, Day, Year) 32. Regisfrar's Signature State MAR 0 4 2004 Registrar

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene 2004 05								
	State of Ma	aryland / Depa	artment of Health and M	lental Hygie	ene 2001	0671.0			
	1 - For State Registrar Unpend Item#23a,27,28a-f,	Per ME,0829,93	hifigate of Death	Reg	1. No.	00/40			
	1. Decedent's Name (First, Middle, Last)			Date of Death    Month	Day Year	3. Time of Death			
n al s	Paul Alexander	Glagola		February	<sup>2</sup> 28, 2004	17:20 M			
r	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death				
	Johns Hopkins Hospital		Baltimore						

Physicia /Medica Examine Funeral

Director permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

al⊩	4a. Facility Name (If not institution		number)						4	c. County	of Dea	th
er	Johns Hopkins	TOOPTCUL			4b. City, Town, or Location of Death  Baltimore  4c. Cour						unty of Death	
	5. Social Security Number	6. Sex	7 Age (In v	rs. last birthe	day) If Under 1	Year If Und	ler 24 Hrs.	8. Date of E	Birth		o Rin	thplace (State or Fo
ĺ			-		Months	Days Hour		(Month, L	Da <i>y, Year</i>	r)	9. Bill	untry)
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4	Usual Residence of Decedent					•						
	10a. State 10b. Count	ty	10c.	City, Town o	or Location							10d. Inside City Li
5	Maryland Baltimore Essex									1 Yes 2		
S	Maryland Baltimore Essex										, , , , , , ,	
ē	10e. Street and Number 10f. Zip Code 10g. Citizen of What Cou									ountry?		
	1658 Poles Road		21221					TT(33				
Funeral Director	1030 FOIES ROad					<u> </u>		USA				
	11. Marital Status	ent of Hispanic	Origin? (Sp	ecify Yes or N	10-		e - Ame ck, Whit	erican Indian,				
	Armed Forces?  If Yes, specify Cuban, Mexican, P  1 ☐ Yes 2 ☐ Mo  If Yes, Give  1 ☐ Yes 2 ☐ No Specify:								, , , , , , , , , , , , , , , , , , , ,		Olac	OR, WITH
þ	3 ☐ Widowed 4 ☐ Divorce	ed If Yes	1 ∐ Yes 2	LXNo Spec	ify:			Specify	V: TATh	ite		
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ete		ent's Education lest grade complete	ed)	(0	lecedent's Usual Give kind of work	done during m	ost of work	ing	16b. I	Kind of Bu	usiness	/Industry
ā	Elementary/Secondary (0-12)	-	ge (1-4or 5+)	11	ife. DO NOT use	e retired)						
Completed	10	30.109	,	Pa	ainter					Cons	tru	ction
	17. Father's Name (First, Middle	a Last)				19 140	ther's Nam	e (First, Midd				
Be			-							Jurnam	10/	
ဂ္	Paul Alexander	Glagola	Sr.			Ro	oberta	a Erdbr	rink			
[]	19a. Informant's Name/Relation	ship (Tvoe. Print)		19b A	Mailing Address (	Street and Nur	nber or Ru	al Route Num	ber City	or Town	State	Zin Code)
	Roberta Milke				58 Poles						J.410, 4	
	TOOCE OF THEIR	(100101)		10.	oo rores	, nodu I			uiu Z	.1441		
	20a. Method of Disposition			D. Place of D	isposition (Name crematory or oth	e of		Date	20c. L	ocation -	City or	Town, State
	1 XBurial 2 ☐ Cremation		om State	_			Marc	1 2004	D- 7	1.2		O-100
	' 4 □Donation 5 □ Other (		ا و	aruens				±,2004	RaT	.C1MO	re (	County, M
	21. Signature of Fuheral Service	e Licensee	Cut.		22. Name and	Address of Fa	cility R	ruzdzin	ski	Fune	ral	Home PA
	1		· /		1407 01	d Fact						nd 21221
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	23a. Pa 1. Inter the disease, of shock, or heart failure. Lis	or complications in	arcaused the d	oatti. Do not	Course file impre	or dying, such	as caldiac	orrespiratory	allest,			Approximate
		st onlylone cause o	on each line.									
11												Interval Between Onset and Deat
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State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Oay Physician 5:50 P M MARCH 01 2004 RUSSELL L. GARDINER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Oeeth 4b. City, Town, or Location of Oeath Examiner MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Yrs. Director 216-07-8036 86 Aug. 26, 1917 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow item 27 is marked other than "natural", or items 23a or 28e-f shov other traumatic event, the Madical Extrating remark to notified at Forest Hill 1 ☐ Yes 2 No Harford Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21050 1702 Rich Way, No. 2C Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after tx□Yes 2□No If Yes, Give Year or Dates to 1946 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 years College (1-4or 5+) furniture store vice president 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Annie V. Gosling Stanislaus K. Gardiner ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1702 Rich Way, No. 2C, Forest Hill, Md. 21050 Marion J. Gardiner/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gdns. 3/5/04 Timonium, Md. 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hlunon resulting in death) /Medical Due to (of s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause University of injury Due to (or as a consequence of) Examine certificate be executed that initiated events and resulting in death) Last burial-t Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.0. ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, pe 4 Unknown 1 ☐ Yes 2 ☐ No 3 🔲 Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1□ Yes 2□Ho Division of Vital Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Tyes 2 No ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Inpatient this funeral dir 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation or Attending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of pertifie 29c. License number 25d, Date signed (Month, Day, Year) 30. Name and addre s of person who completed cause of death (Item 23a) (Type, Print) LoPresti, 31. Date filed (Man Ray (Year) 32 Registrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06750 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4:44 P M February 29,2004 Hilary L. Graybeal /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Cecil Union Hospital Elkton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
December 14,1931 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1□M 2√F Yrs 516-36-2419 72 Enaland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f ehow traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Funeral Director Rising Sun MD Cecil 10g. Citizen of What Country? 10f. Zin Code 10e Street and Number ŏ 21911 12 Buckley Ave. USA iteme 23a death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If ten 27 is marked other themseny injury or other trauments. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2X☐No fYes, Give 1 Never Married 2 Married 1 Yes 2 No Specify Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret McCandles Brunsdon Eric ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12 Buckley Ave., Rising Sun, MD 21911 Clinton B. Graybeal 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State \* 4 □ Donation 5 □ Other (Specify) Brookview Cemetery March 4, 2014 Rising Sun, Maryland 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen Street, Rising Sun, MD 21911 21. Signature of Juneral Service Licenses ich aro Enter the diserte, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part Immedia Cause (Final disease or condition resulting in death) SBU **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Physician/Medicai IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day jo 4 Pregnant at time of death 5 ☐ Other (specify) should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 5 autopsy performed 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 ₺ No 1 \_mpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the Function

Division of Vital Records, P.O. Box 68760,

State Registrar

(Check only ona)

30. Name and a

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29b. Signature and title of certified

MAR 04

(Month, Day, Year)

DHMH 17 Rev 1/2001

**ORIGINAL** 

Stree

29c. License number

D44716

Elkton

M.D.

29d. Date signed (Month, Day, Year)

March 1, 2004

and manner stated.

dress of person who completed cause of death (Item 23a) (Type, Print)

Bow

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 0 1 06751 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** JARRET 9 DONAL ILLIAM 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALTIMORE
If Under 24 Hrs. 8. Date HOPKINS AVVIEW 10 HNS 8. Date of Birth (Month, Day, Year) MAV 31,19 NIA 5. Social Security Number last birthday) Year 7. Age (In yrs Birthplace (State or Foreign Country) **Funeral** Days Min. 218-28-842 12 M 2 ☐ F Months Hours Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MARYLAND 10e. Street and Number 10f. Zip Cod 10g/Citizen of What Country? or Items 23a or 12 AVENUE 2 USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: BLACK À Specify 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life\_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If Item 27 is marked other than any injury or other traumatic event the Mental Informatic event the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 HHGRADE U.S. HOSTAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ပ WILLIAM WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Reral Route Number, City or Town, State, Zip Code) ER) 45 2 RUNN

20b. Place of Disposition (Name of cemetery, crematory or other place) SWAN DAUGHTER GINA OWINGS MILLS MP 21117 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CEME Q3 \*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ODC8 TR. FUNERAL HOME MD, 2/2/ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arfest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or Jornylog Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ESRD The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) the attending physicien Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) P.O. I 1 Yes 2 No detached 9 Unknown 9 Unknown signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 4 Dinknown 2 🗆 No 3 Probably 1 Tyes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an this certificate has autopsy performed? 2 No 2₽ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ဥ 1 Tyes 2 No 2DER/Outpatient 1 🔲 Inpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral dir 27. Manne of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the f 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signafule and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type Print) -10 31. Date filed (Month, Day, Year) MAR 0 4 32. Begistrar's Signature State 4 2004 Registra

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unknown 04-058

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	State of Maryland / Department of Health and Mental Hygiene 2004	067
te	Certificate of Death	001

DOS		1	For State Registrar	- tuto - tuto	Ce	rtificate of Death		Reg. No.	06/22
	Physiciar	776	Decedent's Name (First, Middle, Last		ott Cold	or Ir	2. Date of De Month	nath Day Year	3. Time of Death
	/Medica	1	la. Facility Name (If not institution, give	Paul Arn	ett Gold	4b. City, Town, or Location of	March	1 2004 4c. County of Death	700 a <sup>M</sup>
	Examine	•	10212 Lyons Mill	Baltimore	9				
	Funeral Director		214-02-7634	x 7. Age (li ] <b>x</b> /1 2 ☐ F	n yrs. last birthday 35 Yrs.	If Under 1 Year   If Under 2   Months   Days   Hours	Min. (Month, Da	9. Birth 19, Year) 23, 1968	place (State or Foreign intry) MD
	ryland		Usual Residence of Decedent  10a. State 10b. County		Oc. City, Town or L				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-1s	6010	Maryland Number	J/A		Baltimore	;	10g. Citizen of What Cou	
	3a or 3	2	1504 Ramble wood Roa	ad		212	39	U.S	·
036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, it a Medical Eventher must be recitified at once.	ב ב	11. Marital Status  1   Xever Married   2   Married   3   Widowed   4   Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 Yes 2 Xio Specify:	in? (Specify Yes or No Puerto Rican, etc.)	14. Race - Amer Black, White Specify:	
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212	ad with rgiene.	E -	Elementary/Secondary (0-12)	College (1-4or 5+)		Laborer			AH.
Baltimore, Maryland 21215-0036	uld be file Mental Hy irked oth itic event	0 26	17. Father's Name (First, Middle, Last) Paul A.	Golder Sr.		18. Mother	's Name <i>(First, Middle</i> Pat	, Maiden Sumame) ricia A. Golder	
Man	nd 2 sho lith and 1 27 is mu		19a. Informant's Name/Relationship (T) Paul A. Golder Sr. Fa			ing Address (Street and Number 1504 Ramble wood Ro			p Code)
ore,	es 1 ar of Hea of Heam fitam r otha		20a. Method of Disposition 1 □ <b>X</b> urial 2 □ Cremation 3 □I		20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	Date	20c. Location - City or T	
ij	. Pag tment tant: I		* 4 ☐ Donation 5 ☐ Other (Specify,	)		utus Memorial Park	03/05/04	Baltimo	re , Md
Baj	permil Depar Impor any ir		21. Signature of Funeral Service License	9	2	2. Name and Address of Facility  Estep Brothers	Funeral Home ace_Baltimore, I	P.A.	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	Acations that caused the one cause on each line.  Mutt		nshot wounds		rrest,	Approximate Interval Between Onset and Death
68760,		Medical Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c					
. Box	death cer	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 [ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delin Month	very Day Year
rds, P.0	igne bed	ò	Part II. Other significant conditions co	ntributing to death but n	not resulting in the	underlying cause given in Part I.	23e. Did 1	tobacco use contribute to Yes 2 No 3 □ Pro	the cause of death?
l Reco		Completed					24a. Was auto perfo	psy prior to co ormed? death?	opsy findings available ompletion of cause of 2 \square No
Vita	ysician: Th	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 □ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	Other	of Death (Check only cannot be sing Home 5 - Resi	one) dence 6 <b>O</b> ther (Spec	in) at scene
A Division of Vital Records,	£ 5 m   '	Certification: I	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	One Diese of leive	f Found 6:	Work? 1 □ Yes 250	No Subje	Street and Number or Rui	ral Route Number.
Div		Certi	4 Homicide determined  29a, Certifier 1 Certifying Phy	building, etc. (	(Specify) Side	Shoulder of road	lwy City or To	wn, State) 10212 h	ions mill Rd
	To the Hospital or within 24 hours after To the Funaral Director completely filled in	edical	(Check only 2∑ Medical Exemone)		camination and/or i	nvestigation, in my opinion, deat		date and place, and due	to the cause(s)
	To tha I within 2 To the I complet	Ž	29b. Signature and title of certifier $\mathcal{U}$ .	mid		29c. License number OCME		29d. Date signed (Month. March 2 2004	
	Q		30. Name and address of person who o		th (Item 23a) (Type	n, Print) 111 Penn St	reet, Balti	more, Maryla	nd 21201

State Registrar 31. Date filed (Month, Day, Year)
MAR 0 4 2004

32 Registrar's Signature

And !

	Amend Item 8 per state Registrar	" FH,G829,0	3/10/04dhb Ce	rtificate of l	Death	Re	19. No. 2004	06753
14.	1. Decedent's Name (First, Middle, La.	st)	^			2. Date of Death	h Day Year	3. Time of Death
ıysician Medical	Hazel		Gr	ove		March	2 2004	0440 AM
caminer	4a. Facility Name (If not institution, give		- 1	4b. City, Town, or	Location of Death		4c. County of Deet	h
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ral	5. Social Security Number 6. S 213-26-5213	ex	ge (In yrs. last birthday, 7 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	7 (a) Co	hplace (State or Foreign untry)
or	Usual Residence of Decedent	**	72 Yrs.			MARCH 1	5,1931 P	ENNSYLVAN
	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
to	MD BALT	IMORE	BAL	TIMORE				1 ☐ Yes 2 📉 No
Lec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
OF	7323 GERMAN HI	LL ROAD		212	22		U.S.A.	
Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S)	pecify Yes or No-	14. Race - Ame Black, Whit	
Ŧ	1 Never Married 2 Married	1 Tes 2 T		1 ☐ Yes 2 ☑ No	Specify:		Specify:	
d by	3 ☐XWidowed 4 ☐ Divorced	Year or Dates					W	HITE
Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	furing most of wor.	king	16b. Kind of Business/	Industry
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	17. Father's Name (First, Middle, Last,	)	1100	DEWIL E	18. Mother's Nam	ne (First, Middle, A	DOMESTI  Maiden Sumame)	<u> </u>
Be						, ,		
L <sub>O</sub>	'I'HOMAS CRA		19h Mail	ng Address (Street	KATH		City or Town, State, 2	7in Code)
	GORDON CRAIG/							
	20a. Method of Disposition	DIOTHER	20b. Place of Disp	osition (Name of		Date 2	BURG, FLA 20c. Location - City or	Town, State
	1 X Burial 2 ☐ Cremation 3 ☐		9	matory or other plac SOFFAI		101	DAT MENOD	
	* 4 □ Donation 5 □ Other (Specifical Signature of Funeral Service Licer		2	2 Name and Address	s of Facility			E, MARYLANI
	21. Signature of Furification vice Electric	2		ILLY &	ZEILER	INC. FU	NERAL HO	ME
	23a. Part1. Enter the disease, or com	plications that cause					,BALTO.,	Approximate
7.1	shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.					Interval Between Onset and Death
	disease or condition resulting in death)	a Gostroin		aing				24 hours
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e e	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequence of).					
ᇤ	cause. Enter Underlying Cause (Disease or injury that initiated events							
Examiner	resulting in death) Last	Due to (or a	s a consequence of):					
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edi							-1	
Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		□Ectopic pregnancy			23d. Date of del	ivery
Icla	in the past 12 months? 1 ☐ Yes 2 Ø No	4 Pregnant		Dectopic pregnancy  Other (specify)			Month	Day Year
hys	9 🗆 Unknown	9 Unknown				_		7.7
by P	Part II. Other significant conditions of	contributing to death	but not resulting in the t	inderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ed	Breast Concer, D	iahetes				1 🗌 Ye	s 200 No 3□Pr	obably 4 Unknown
Completed						24a. Was ar		topsy findings available completion of cause of
Eo						perform		_
BeC	25. Was case referred to medical				26. Place of Dea	th (Check only one	N	
0	examiner? 1 🗆 Yes 🏻 🏖 No	Hospital: 1 XInpat	ient 2 ER/Outpatie	nt 3 DOA Othe	er		nce 6 ☐Other (Spe	cify)
n: T	27. Manner of Death	28a Date of In	jury 28b. Time o	of 28c. Injury	at	28d. Describe ho	w injury occurred	
atlo	1 Natural 5 Pending 2 Accident investigation		ay roasy injury		Yes 2 □ No			
iffe	3 Suicide 6 Could not b	286. Flace of II	njury - At home, farm, st	reet, factory, office		28f. Location (Str City or Town	reet and Number or Ru . State)	ral Route Number,
Certification:	To mondo	building,	ote: (Speeny)				,,	
edical (	(Check only 2 Medical Exar	niner: On the basis	t of my knowledge, dea of examination and/or in					
Med	29b. Signature and title of certifier	and manner s	natou.	29c. License	number	29	d. Date signed (Monti	h, Day, Year)
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	20. Name and address of person who Linn Exert MD Johns				. Ditte	nA.	2)221	
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State	31. Date filed (Month, Day, Year)	32 Hanie	trar's Signature	4 10				

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 06754 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year GODMAN 440PM **Physician** IRGINIA MARCH 2006 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RANDALISTOWN BALTIMORE SURACUTE NORTHWEST AT If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y 8/3/1917 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 1 F 86 Virginia 220-05-1299 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h Counts r than "natural", or items 23s or 28s-f show the Medical Examiner must be nutified at txTxYes 2 □ No MD N/A Director Baltimore 10g. Cilizen of What Country? 10f. Zip Code 10e. Street and Number 5658 Kayon Avenue U.S.A. 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marilal Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedeni's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. OO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Fabric Company other 1 permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Cocilova Adeline Deluca 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Westwood 5658 Kavon Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Holy Redeemer 3/5/2004 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Signature of Eunecal Service Licenses 6415 Belair Road Baltimore, Maryland 21206 Approximate Interval Between Onset and Death iplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Pert1. Enter the disease, or emplications that caused the shock, or heart failure ast only one cause on each line RINELOVANIAN Immediate Cause (Eina disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Box 68780, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were aulopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy performed? Yes 2000 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one Hospital: Other: 1 Yes 2 No Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 1 Inpatient 2 ER/Outpatient After this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Matural 5 Pending М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1/Creatifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 37333 MARCH 2, ZOOL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), BAUTO MO 21,33 MA NHC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06755 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 150 PM MADELINE HELOWICZ 262004 ebra /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE N/A STELLA MARIS @ MERCY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days **Funeral** Months Hours MARYLAND 1 □ M 2 🖾 F 212-07-9352 84 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County is 1 and 2 should be filed within 72 hours efter death with the Maryle of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shorother treumatic event, the Medical Examinal must be notified at 1 Yes 2 No Funeral Director BALTIMORE MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21231 1728 FLEET STREET USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ۵ Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced Year or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 HOMEMAKER HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If Item 27 is marked to any Injury or other traumatic ev MARYANNA THEODORE ZIENTAK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MR. MARION HELOWICZ / SON 1728 FLEET STREET BALTIMORE, MD. 21231 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State STANISLAUS CEME. 3/1/04 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) KACZOROWSKI acijuneral Home P.A. 21. Signature of Funeral Service Licensee 1201 DUNDALK AVE. BALTIMORE, MD. Castri 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Cuncer Examiner Due to (or as a consequence of) Examiner burial-trensit Hospital or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS DICC ဥ 1 ☐ Yes 2 ☐ No this 28b. Time of 28c. Injury at Work? 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: A 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral C edicai 29a. Certifier 12 Certifying Phyaician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29d. Date sign∳d (Month, Day, Year) 29b. Signature and title of certifier 2 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 bero 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 4 2004 Registrar

			For State Registrar	State of Marylan	nd / Depa	artment of F	lealth and	Mental Hy	giene 200	4 06756
١	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	Day Yea	
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>	Examin	er	4a. Fecility Name (If not institution, give s			- "	r Location of Deat	h	4c. County of D	
7	Francis		Southern Maryland  5. Social Security Number 6. Sex		last birthday)	Clinton If Under 1 Year	If Under 24 Hrs	8. Date of Birt	Prince G	eorges  Birthplece (State or Foreign Country)
	Funeral Director			km 2□F 7	V	Months Days	Hours Min.	(Month, Da Dec . 2 .		shington, DC
	pu ,		Usual Residence of Decedent	100 6	ty, Town or Lo	eation				10d. Inside City Limits
	ahov shov	Į.	10a, State 10b. County							1 ☐ Yes 2X No
	28a-f	ect	Maryland Prince Geo	orges le	mple H	111S 10f. Zip Code			10g. Citizen of What	Country?
	3a or	Funeral Director	4506 Henderson Road	1		20748			USA	
	death	nera		12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Decedent of H if Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No-	14. Race - A Black, W	merican Indian,
0	or ite		1 Never Married 2 Married	1 Yes 2 No		1 ☐ Yes 2 🛣 No		,	Specify: W	
200	hours tural	ed by	3 Widowed 4 Divorced			dent's Usual Occup	ation		16b. Kind of Busine	
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ylallu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
7	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. It marked other than "natural", or Items 23a or 28a-f show umatic event, it a Medicul Eratul writing Le traffiled at	5	Dabney Carr I  19a. Informant's Name/Relationship (Type	Harrison	10h Mailie	- Address /Ctrast	Mary	Addisc	on Marb	
Z	01 (0 00 00		Beverly R. Harri			•			ills. MD 2	
ני	<b>二子写为</b>		20a. Method of Disposition	20b. F		sition (Name of natory or other place		Date	20c. Location - City	
	permit. Pages of Department of Inportant: If Ite any injury or of Angles		1 ☐ Burial 2 XCremation 3 ☐ Ri 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ematory	1	h 2.2004	- Edgewate	r. Maryland
2	permit. Departm importa any inju		21. Signature of Juneral Service License		22	Name and Addres	ss of Facility			74
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}	Physician		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the deat le cause on each line.  Metalahi (a	runona	er the mode of dyin	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq						
	ם וב	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quance off:					
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	quence of):					
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200	ath cer ttendir or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	al death 3	Ectopic pregnancy			23d. Date of of Month	delivery Day Year
	the at	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	death 5□	Other (specify)				<b></b> ,
	that the ed by detac		Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
SOLON SOLON	quires n sign	q p	Bronchopreuminia					1 🗆 Y	′es 2□No 3⊡	Probably 4 Unknown
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5	Physic this crail direct	٦.	1 Yes 2 Alo	28a. Date of Injury	ER/Outpatien	I 3 DOA	4   Nursing F		tence 6 Other (S	pecify)
5	nding th. : After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yeer)	Injury	Worl	k? Yes 2 No		,,	
	Atter er dea rector by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str fv)	eet, factory, office		28f. Location (S City or Ton	Street and Number or vn. State)	Rural Route Number,
2	ital or irs aft ral Dii iled in									
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 4s hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical		nician: To the best of my knowner: On the basis of examination and manner stated.						
	To th withir To th comp	Me	29b. Signature and Alle of certifier			29c. Licensi	e number		29d. Date signed (Mo	enth, Dey, Year)
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	10		30. Name and address of person who co		п 23a) (Туре, M Анги	100	t 310 W	as hing ton	De 20032	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	low Val		J		
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03.01-04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004For State Registrar AMEND ITEM #19a PER FH G829 3/04/0/Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 **Physician** March 1, 5:53 Ам /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Towson Baltimore Greater Baltimore Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 250 - 16-596 Usual Residence of Decedent Director 10b. Count 10c. City, Town or Location 10d. Inside City Limits 10a State or 28a-f ahow other treumatic event, the Medical Examiner must be notified at Yes 2 □ No Director 10f. Zip Code and Number 10g. Citizen of What Country or Iteme 23a 200016 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian, 11. Marital Status Black, White, etc. ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Z Specify Widowed 4 Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NO (use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If item 27 is marked other tran "na any injury or other treumatic avantations." Elementary/8econdary (0-12) College (1-4or 5+) Maiden Sumame (First, Middle, Last, Mother's Name (First, Middle 17. Father's Name Be 660 JUDITH Na SNOWDEN HIJ DAUGHTER Place of Disposition (Name of cemetery, crematory or other p Date Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State a Service Licenses of Facility ZSN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval between Onset and Death Immediate Cause (Final disease or condition PS15 **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner E C Sautentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed UR use as the burial-tran and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. the attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy jo in the past 12 months? Year Month 5 Other (specify) 1 ☐ Yes 2 ☐ No page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 2 12 No 3 Probably 4 Unknown 1 ☐ Yes this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 TYes 1 Yes 212 No Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 1√ Yes 2 No 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation Division 1 Natural within 24 hours after death.

To the Funerel Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 [6] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 16 6 Pall 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 4 2004

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** b (10 f 29 206 GORDON DALE HOCK /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 59 HOSP, KOS & do 110/8 ť MO 8. Date of Birth Month, Day JUNE 29 If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min. Hours 1₩ 2□F 58 MD. 218-42-1018 Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1√ Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21224 7271 GOUGH STREET or Items 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) COAST GUARD Elementary/Secondary (0-12) 12TH is marked other than College (1-4or 5+) ould be filed within Mental Hygiene. DEPT. OF TRANSPORTATION PAINTER 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be MARIE E. FALKENSTEIN GORDON PETER HOCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is sny injury or other trau 7271 GOUGH STREET, BALTIMORE, MARYLAND 21224 WANDA HOCK/WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition BALTIMORE WASHINGTON CREMATORY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MATORY 3/3/04 LAUREL, MARYLAND
22. Name and Address of Facility CHARLES S. ZEILER & SON, INC.
6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 21. Signature of Funeral Service Licenses 23a. Pert1 Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Physician craf resulting in death) /Medical Due to (or as a consequence of) Examiner umnia Sequentially list conditions, if any, leading to immediate cause. In a Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗆 Yes 2 12/No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 Z No Hospital: 1 Inpatient 2 ER/Outpatient 3 DDA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification; To in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 🗹 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flan NKI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 04

State of Maryland / Department of Health and Mental Hygiene 2004 06759 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death February 28, 2004 Marjorie R. Harris Physician 9:27 p. M /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia Howard Sunrise Assisted Living of Columbia If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sex 1□M 2XF **Funeral** Days Hours 189-20-6698 Director January 1, 1914 Pennsylvania Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 1 ☐ Yes 2 No Funeral Director Columbia Maryland Howard 10g. Cilizen of Whal Country? 10e. Street and Number 10f. Zip Code 21045 U.S.A. 9670 Basket Ring Rd. 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Caban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, While, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homermaker 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John G. Young Mary Jane Birkbeck 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9670 Basket Ring Rd. Columbia, Maryland 21045 Ms. Marjorie Deininger Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/01/2004 Baltimore, MD **Bayview Crematory** 4 Donation ignatu e of Furferal Service License 22. Name and Address of Facility Verlle. Slack Funeral Home, P.A MO0535 3871 Old Columbia Pike Ellicott City, MD 21043 anti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final nhoma **Physician** year disease or condition esulting in death) /Medical Due to (dr as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner burial-transit Due to (or as a consequence of): Physician/Medicai as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? of Vital Records, þ 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 1 ☐ Yes 2 No certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) ASSISTED Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 X No 2 6 ther (Specify this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospitel or Attending 1 Natural 2 Accident Injury 5 Pending after death.

Director: Aff
in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) M.D. 03,01,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) columbix, MD21044 10780 Hickory Ridge Road, Harry レジ 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

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		1	For State Registrar	State of M	aryland	d / Dep	artment of H rtificate of I	ealth and	Mental Hygi	ene 2	004	06760
			Decedent's Name (First, Middle, La.	st)					2. Date of Death			3. Time of Death
	sicia		DONALD JOH	in Imi	G				MARCH	O (	2004	0955 M
	edica mine		4a. Facility Name (If not institution, give		Nus	ESING	4b. Cily, Town, or			1	nty of Death	
-			BROOKE GROVE REHAB	ILITATION A	NO CE	NIER	SAND	Y SPRIM	JU	Mos	STGON	IERY
Fund Direct	_		5. Social Security Number 6. S		ge (In yrs. Ia <b>90</b>		If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Birthp Coun	lace (State or Foreign try) Ois
D >	2	-	Usual Residence of Decedent  10a. State 10b. County		10c City	Town or L	ocation				1:	0d. Inside City Limits
shor		5		-nv								XX Yes 2 □ No
the N		ect	MARYLAND MONTGOME  10e. Street and Number	ERT	3	SANDY S	10f. Zip Code		10	a. Citizen o	of What Coun	trv?
with or		ă	1637 HICKORY KNOLL F	ROAD				20860			5.A.	
eath		era	11. Marital Status	12. Was Decedent	Ever in U.S	6. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (	Specify Yes or No-		ace - Americ	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Pygiene. Important: If item 27 is marked other than "netural; or Items 23a or 28a-f show	Management	by Funeral Director	1 Never Married 2 Married  3 XXWidowed 4 Divorced	Armed Forces? 1 ☐ Yes ★▼ If Yes, Give Year or Dates:			If Yes, specify Cuba  1 ☐ Yes 2XXNo	n, Mexican, Pue Specify:	rto Rican, etc.)	Spec	lack, White, with the sify:	
2 hor			15. Decadent's E	ducation		16a. Dece	dent's Usual Occupa	ation	1	6b. Kind of	Business/Inc	lustry
<b>12</b> 15 15 15 15 15 15 15 15 15 15 15 15 15		e l	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work done of DO NOT use retired	uring most of wo )	orking			
21. d will giene	2	Completed	12	4		T	EACHER				UCATION	<u> </u>
Maryland 21215-0036 nd 2 should be filed within 72 hours att th and Mental Hygiene. 27 Is marked other then "netural", or	Meven.	Be	17. Father's Name (First, Middle, Last,	)					ime (First, Middle, M	laiden Sum	a <i>m</i> e)	
V Sould		၉	GEORGE IMIG  19a. Informant's Name/Relationship (	Tuna Printl	-	10b Maili	ing Address (Streets		Rural Route Number,	City or Tow	n State Zin	Code)
Mai 12 st h and 7 ls n			DAVID IMIG	Type, Filin)								
e, land teattl		-	20a, Method of Disposition		20b. Pla	A CONTRACTOR OF THE PARTY OF TH			Date 2		n - City or To	
Or ges	6	-	1 🗓 Surial 2 🗆 Cremation 🤾				osition (Name of matory or other plac					
timen trans	l light		*4 □ Donation 5 □ Other (Specif		WOO	1	MEM. PARK			JOLIET,		
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/760, / Medi Exami Exami Asician and Asician and	cai ner	cal Examiner	23a. Part 1. Enter the disease, or common shock, or heart failure. List on lammediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	ACHU a conseque a conseque CED	ence of):	EMENT.		acon respiratory arre	31,	U	Approximate Interval Between Onset and Death DAYS USECUS  JEARS
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phy	ched for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3[	□Ectopic pregnancy □ Other (specify)				Date of delive	ry Day Year
ds, P. uires that t signed by	nd be delad		Part II. Other significant conditions of	contributing to death t	out not resul	Iting in the u	underlying cause give	en in Part I.	23e. Did tob	-		e cause of death?
Division of Vital Record to Attending Physicien: The law requir after death. Director: After this certificate has been si	age z snou	Completed							24a. Was an autopsy perform		prior to con death?	osy findings available npletion of cause of
ital	dor.	Bec	25. Was case referred to medical					26. Place of De	eath (Check only one			
f V nysicl	allo	TO B	examiner? 1 ☐ Yes <b>25</b> No	Hospital: 1 ☐ Inpati	ent 2 🗆 E	R/Outpatie	nt 3□ DOA Othe	or: Mursing	Home 5☐ Resider	nce 6 🗆 C	ther (Specify	")
On O oding Ph ith. : After th	Tunerai		27. Manner of Death  1,25 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inji (Month, Da	ury ay Ye <i>ar)</i>	28b. Time o Injury	Work	/at ⟨? Yes 2 □No	28d. Describe ho	winjury occ	urred	
Divis	tii ka ui b	Certification:	3 Suicide 6 Could not be determined	200. Place of III	jury - At hor tc. (Specify)	me, farm, st	reet, factory, office		28I. Location (Str. City or Town,	eet and Nur State)	mber or Rura	l Route Number,
To the Hospital within 24 hours at To the Funerel C	etely fille	Medical C		nysicien: To the best miner: On the basis of and manner st	of examinati							
To th within To th	comp	Me	29b. Signature and title of certifier	A		LIK.	29c. License				ned (Month, i	
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-7	)		30. Name and address of person who GRALE BROOKE HUF	ATTENDI completed cause of TMAN, M.D. 32. Regist	death (Item	23a) (Type S LAI	SESCHOOL F	COAD SAN	Day Spring	MAR	YLAN	20860
Re	Stat gistra	٠ ۱	31. Date filed (Month, Day, Year)  MAR 0 4	2004 32. Regist	rar's Signati	ure	Is April	Kg/ :				

			1 - For State Registrar		State o	f Maryla	nd / Depa	artmen <i>rtificat</i>	t of H e of L	lealth : Death	and M	lental Hy	gier Reg. M	1e2004	(	1676	1
	Physici /Medi		1. Decedent's Name (First, Mid Corl	idie, Last) EQU	ard	/	•	Jone	es	J	۲,	2. Date of De Month	ath	Day Year		Time of Death	v
	Examir Funeral Director	ner	4a. Facility Name (If not institu Johns Hopkins 5. Social Security Number 218–62–4959	Bay 6. Sex	view i	Medica	LEHER s. last birthday)	4b. City,  If Under Months	Ba/1	Location FMC If Under Hours	ne	8. Date of Bir	th IV. Yea	9. Bir	thplace	State or Forei	gn
1	D		Usual Residence of Decedent 10a. State 10b. Cour	ity		10c. C	50 Yrs. City, Town or Lo	ocation				Septembe		1,1953 N	10d. Ir	side City Limit	s
	h the Mar r 28e-f st	Director	MD. Hari	ord			Edgewo	od 10f. Zip	Code				10g. C	Citizen of What Co	L	□Yes 2XN	0
9003	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then the marked other than "natural", or Items §3s or 28e-1 show other treumstic event, the Madical Examiner mat be notified as	by Funerai	3403 Periwink  1. Marital Status  1. Never Married XXM 3 Widowed 4 Divorce	arned ed	2. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or Da	2 <b>X</b> ]No ′e		Was Deced	offy Cubar	spanic Ori	n, Puerto	ecify Yes or No Rican, etc.)	-	USA  14. Race - Ame Black, Whit  Specify: Wh	e, etc.	dian,	
ınd 21215-0036	be filed within 72 that Hygiene. Id other than "nate event, the Macies.	Be Completed	(Specify only high Elementary/Secondary (0-12 12 years 17. Father's Name (First, Middle 19 19 19 19 19 19 19 19 19 19 19 19 19	e, Last)		-4or 5+)	16a. Dece (Give life. Manag	<i>ki</i> n <b>d</b> of wor DO NOT us	rk done d se retired)	furing mos	er's Name	(First, Middle,	Po	Kind of Business Wer Gene Servic an Sumame)	rati		
Maryland	12 should h and Men 7 is marke	2	Carl Jones Sr.  19a. Informant's Name/Relation	nship (Typ	•	· c			(Street a		er or Rura	I Route Numbe		or Town, State, 2	Zip Code	)	
altimore, I	Page nent o nnt: If ury or		Kristina Jones  20a. Method of Disposition  1 Burial 2 Crematio  4 Donation 5 Other	n 3 □Re		State	Place of Dispo cemetery, crem yview C	sition (Nam natory or ot	ne of ther place		Г	ch 3,	20c.	. 21040 Location - City or timore C			
Ball	permit. Pag Department: Important: I any injury o		21. Signature of Funeral Service  Thomas	r C	. 6	nnel	7	110 S	olle	rs Po	oint	ome Of I Road, I	Dun Dun	dalk,P.A dalk,Md.	_		
8760,	Physician /Medical Examiner, transit the printing full full full full full full full ful	dical Examiner	23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. b. c. d.	Due to (	ach line.  diac or as a conse	quence of):				cardiac	respiratory ar	rest,		Inter	oximate value between the and Death that and Death the and Death that are the and the	
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	To the Hospital or within 24 hours after To the Funerel Discompletely filled in	Medicai	one)	II EXAMINE	and mann	er stated.	ation and/or inv	estigation,	in my opii	nion, deat	d place, a h occurre	d at the time, o	late an	s) and manner as d place, and due	to the ca		
	F 1 5 5	_	29b. Signature and title of certif	IM C		Physicic BMC		Ţ	License )419				,	ate signed (Month	, Day, Y	ear)	
	19		30. Name and address of person Johns Hopkin	s Bar	رمزوص	Med Cf	1, 49	orint) 40 E	asi	ern	Ave	nue le	propal	as MI Inmore,	MD	21224	
	Sta Registra		31. Date filed (Menth Pay, Yea	2004	32/Re	gistrar's Signa	ature	- 00									

State of Maryland / Department of Health and Mental Hygiene 2004 06762 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Anna Frances Kaminski 4, 2004 ам March 5:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 527 45th St. Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Yeer)
April 27, 1914 Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F 89 Yrs. Director 213 03 9317 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28e-f ehow the Wedical Examiner must be notified at 1 Yes 2 No Maryland Baltimore Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WIT 1510 Galena Rd. 21221 USA Funeral filed within 72 hours after death 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 Depertment of Health and Mental Hygis Importent: If item 27 Ie marked other eny injury or other treumatic event, IL ODGE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Frank Palczynski Rose Jankiewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Gary Kaminski (Son) 527 45 th St. Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 28 Burial 2 Cremation 3 Removal from State St. Stanislaus Cemetery 3/8/2004 Baltimore, Md. 1 4 ☐ Donation 5 ☐ Other (Specify) permit. <sup>22 Name and Address of Facility</sup>
Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, 21. Signature of Funeral Service Licenses Md. 21221 Flam. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metestotic Copy Concer 1 year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospitel or Attending Physicien: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year þ in the past 12 months? 1 ☐ Yes 2 ☑No Month Day 4 Pregnant at time of death 5 Other (specify) P. 0. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tyes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Special) Hospital: 1 | Inpatient 2 | EP/Outpatient 3 | DOA 2 1 ☐ Yes 2 XNo 28b. Time of Injury 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: A 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c License number 29b. Signature and title of could 29d. Date signed (Month, Day, Year) DODSZAZX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sailevard MARI ANNE NIDIRY 1792 31. Date filed (Month, Pay Year) 32. Resstrar's Signature State 4 2004 Registrar Assoll

			For State Registrar	State	of Mar	ryland /	Depa Cer	rtment of H tificate of L	ealth and Death	d Mental H	ygiei Reg.	ne 200	4	06763
			Decedent's Name (First, Middle, Li	ist)						2. Date of I		Day Van		3. Time of Death
	Physicia		Mildred M K	remer						Month		Day Yea 2004	ar	9:08 P M
	/Medic		4a. Fecility Name (If not institution, gi		ımber)			4b. City, Town, or	Location of De	eath		4c. County of D	eath	
			Greater Baltimo	re Medi	cal (	Center	:	Towson				Baltimo	re	
yes F	uneral			Sex	7. Age	(In yrs. last b	oirthday)	If Under 1 Year Months Days	If Under 24 H	fin. 8. Date of E	Birth Day, Ye	ar) 9. 8	Birthple	ce (State or Foreign
	irector		215 03 6665	1 □ M 2 □ F	93	·	Yrs.	Mionino	1,00,0	April				ore,Maryla
pu	*		Usual Residence of Decedent  10a, State 10b, County		1	10c. City, To	wn or Lo	cation					10d	I. Inside City Limits
lanyle	sho in	5				•								1 □Yes 2 □No
the N	28e-1	Director	Maryland Baltimore			Baltimo	re w	10f. Zip Code			10a.	Citizen of What	Country	
with	- O - O		35 Melken Court					21236			US			
eath	18 23 III	era	11, Marital Status	12. Was Dec	edent Ev	ver in U.S.	13. V	Vas Decedent of Hi	ispanic Origin?	(Specify Yes or I	1	14. Race - A		
flerd	r Ite	Funeral	1 Never Married 2 Married	Armed F 1 ☐ Yes	2 No	)	If	Yes, specify Cuba	n, Mexican, Pu	uerto Rican, etc.)		Black, W	hite, etc	c.
ursa	- B	by	3 Widowed 4 Divorced	If Yes, G Year or I			1	☐ Yes 2X No	Specify:			Specify: W	hite	
72 ho	natur lice	Completed	15. Decedent's E (Specify only highest g	ducation	)	16	a. Deced	ent's Usual Occupa	ation during most of	working	16b	. Kind of Busine	ss/Indu	stry
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pnonld	narke natic	2	George A Grebe	(T Driet)		1.0	Dh. Mailin	- Address (Ctroots		Marie W			~ 7i= C	adal
12 sh	I is n		19a. Informant's Name/Relationship  Mary Ann Bantz	(Type, Pnnt)				g Address (Street a ken Court					e, zip c	ode)
1 and	m 2		Mary Ann Bantz  20a. Method of Disposition					sition (Name of	Dartillor	Date	_	Location - City	or Town	n. State
96 s			1 Burial 2 Cremation 3		State	cemet	tery, cren	atory or other place emetery Ma		ΥΥ <sub>1</sub>		kesville,		
à	njury		* 4 □Donation 5 □ Other (Spec 21. Signature of Funeral Sentice Lice			Laine V				<del></del>	Эу	NESVILLE,	reily.	Latu
D ed	Department of results and wenter hyperes.  Department of results and wenter hyperes.  Exercities trained to the transition of the results of		Months office	John (	M	mi	I	Name and Address ASSAM Fund	ral Home	e Inc		-1 2122		
			23a. Part1. Enter the disease, or cor	nplications that	caused	he death. Do	o not ente	401 Belair er the mode of dyin	g, such as care	diac or respiratory	arrest,	na 21236	A	pproximate
*			shock, or heart failure. List ont Immediate Cause (Final	y one cause on	$\bigcirc$								C	nterval Between Onset and Death
	ysician Iedical		disease or condition resulting in death)	a		consequenc	_	A					16	, DAYS
Ex	aminer		1	500 (0	-	- GEST		HEART	- F	AILURE			0	NE WEEK
* 3	-	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to		consequenc		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
penno	ansit	Examiner	that initiated events	С.										
, exe	an ar rial-ti	EX	resulting in death) Last	Due to	(or as a	consequenc	e of):							
ate be ex	he bu	dicai	•	d									-	
rific	ng pl		IF FEMALE:											
ath cer	ttend or use	lan/	23b. Was decedent pregnant in the past 12 months?		birth 2	☐ Fetal dea		Ectopic pregnancy				23d. Date of Month	,	ay Year
. e	the a	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Preg 9⊟Unki		me of death	5 ∟	Other (specify)			-			
hatt	d by detac		Part II. Other significent conditions	contributing to	death but	not resulting	in the ur	ndertving cause give	en in Part I.	23e. Di	d tobaco	co use contribute	e to the	cause of death?
w requires t	signe d be	d by		,				,,		1.0	Yes	2 No 3	Probab	ly 4 Unknown
5 g	peen	Completed								24a. W	200	24h Word	autono	y findings available
e lav	has 3e 2	m								au	topsy rformed	prior	to comp	letion of cause of
1 2	ficate r, pa		OF Man and referred to medical						00 Pl/	1 Yes		400 1□Y	'es 2	□ No
VILCIAN:	certii	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	Înpatient	1 2 ER/0	Outpetion	t 3 DOA Oth	05	Death (Check on)		e Dothar (6	`noo.6.1	
5 £	r this ral di	<b>—</b>	27. Manner of Death	28a. Date	of Injury	28b	. Time of	28c. Injun	y at			njury occurred	pecity)	
or Attending Phy	th. : Afte : fune	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigati		nth, Day	Year)	Injury	M 1	k? Yes 2 □ No					
Atte	ctor oy the	fica	3 Suicide 6 Could not	be 28e. Place			farm, stre	eet, factory, office		28f. Location	(Street	t and Number or	Rural P	Route Number,
5 5	Dira d in b	Certification:	4  Homicide	Dulle	ing, etc.	(Specify)				City or 1	own, S	iate)		
ospita	within 24 hours after death.  To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.							occurred at the tin						
Pe H	n 24 he Fu	Medical	(Check only 2 Madical Expone)		nner state		and/or inv	vestigation, in my o	pinion, death c	occurred at the tim	e, date	and place, and o	due to tr	ne cause(s)
Tot	To ti com	Σ	29b. Signature and title of certifier	pn:				29c. License				Date signed (Mo	onth, Da	
	$\dot{\wedge}$		for O.	cer		^ >			5883		1	arch e		2004
	4		30. Name and address of person wh	completed cau	ise of dea	ath (Item 23a	a) (Type,	Print)	, ,	A #25-1			_	1 2 3 1 3 1 5 1
	3.55	257	John Clarke	MI)		670	1 1	U. AK Ch	ierles S	T, - 5053		10-50-	70	ryland Elect
	Sta		31. Date filed (Month, Day, Year)	32.	Hegistrar	s Signature	A	south						
	Regist	rar	MAR 0 4 2004	1 Carlow	7	10	17	- 6						

			1 - For State Registrar	State of Mar	yland / Depa <i>Cei</i>	artment of H	lealth and <i>Death</i>	Mental Hy	giene 2	004	06761
			1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath		3. Time of Death
	Physici /Medio		Dorothy V. Keilh	oltz				Month	Day	Zoou	11:15AM
)	Examir		4a. Facility Name (If not institution, giv	s street and number)		4b. City, Town, or	r Location of Dea		4c. Cou	nty of Death	<u> </u>
			Calvert Manor He	althcare Ce	nter	Risina	Sun		Coo	cil	
	Funeral		5. Social Security Number 6. S	ex 7. Age (	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		h		ace (State or Foreign
L	Director		217 12-7470	UM 281 F	89 Yrs.		110010	Februar	4 6,19	915	Maryland
	and		Usual Residence of Decedent  10a. Slate 10b. County	1	Oc. City, Town or Lo	cation		<del> </del>		1/	0d. Inside City Limits
	Manyl Feho	ŏ	MD Cecil							"	1 ☐ Yes 2 ☑ No
	28a	Director	10e. Street and Number		Rising St	10f. Zip Code			10a Citizon	of What Coun	
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Hema 23e or 28e-f ehow ent, the Medical Examinat must be indiffied at	<u>ā</u>	1881 Telegraph Ro	nad		21911			-		
	ma 2	Funerai	11. Marital Status	12. Was Decedent Eve	er in U.S. 13. \	Was Decedent of H	ispanic Origin? (	Specify Yes or No-	USA 14. F	Race - America	an Indian.
9	or ite	Ē	1XXNever Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	'	f Yes, specify Cuba	ın, Mexican, Pue	rto Rican, etc.)		Black, White, e	
8	ral', c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Spe	city: Whi	te
5-0	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Deced	lent's Usual Occup- kind of work done of	ation	orkina	16b. Kind of	Business/Ind	lustry
2	of Man	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	0	, nang			
'n	led v fygie her t	S	12		CLE	rical wo			Chen	rical C	ompany
Maryland 21215-0036	tall H	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,		ame)	
Ž	hould d Mer mark matic	은	Clyde Kirk Keilho  19a. Informant's Name/Relationship (		400 14 17			sie Garv			
Z	d 2 sl th an 7 is r traur		Donald Keilholtz	ype, Printj				lural Route Number			
	s 1 and 2 of Health a item 27 is other trac		20a. Method of Disposition		20b. Place of Dispo-	sition (Name of		Lancast		. 17602 n - City or Tov	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f ehow any injury or other traumatic event, the Medical Examination and the colling at once.		1 Burial 2 X Cremation 3 □	Removal from State	cemetery, cren	natory or other plac	''				
==	ortani ortani injury		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licen</li> </ul>	. ,	Brookvieu	) Cemeteri	y Marc	h 8, 200	4 Ris	ing Su	n. MD
Ba	Depermine Deperm	1	1 Perland 8	1 400	chie "	111 9 0	LOOK St	T. Foard	tuner	al Hom	6
	25		23a. Pert1. Enter the disease, or companies shock or heart failure. List only	olications has caused the	e death. Do not ente	er the mode of dvine	g, such as cardia	eet, Ris	est Su		Z   9     Approximate
	Physician		Immediate Cause (Final	~							Interval Between Onset and Death
jt.	/Medical		disease or condition resulting in death)	a. Due to (or as a c	ODSERVEDOR OFF	men 17P	E				
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· ·		ner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that	b. Due to (or as a c	unsequence of):						
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8760,	icate be executed physicien and s the burial-transit	dicai		d							
Ó	eath certific attending p	Mec	IF FEMALE:	-							
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of a 1 Live birth 2	Fetal death 3	Ectopic pregnancy				ate of deliver	
	the a	sic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐Pregnant at tim 9☐ Unknown	ne of death 5	Other (specify)			,	NOTITI L	Day Year
P.O.	that the de led by the a detached f	by Physician/Me	Part II. Other significant conditions of	ontributing to death but n	not resulting in the un	derlying cause give	n in Part I	23a Did tot	22000 1100 00	atributo to the	cause of death?
ds,	signed d be del	d by	CONONDAY ART	0	at to soming in the si	donying cause give	ATTITE CALLE.		es 2 🔀 No		bly 4 \(\begin{align*} \text{Unknown} \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\
Ö	w require	ete	ATRIAL FIBRIL								DIY 4 GONKHOWN
Ř	has ge 2	Completed						24a. Was a autops perform	y	. Were autop: prior to com death?	sy findings available pletion of cause of
g	icien: The certificate he rector, page			15-TYPE 2				1□ Yes 2	PS No	1 ☐ Yes 2	ZNo
Division of Vital Records,	sicie certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	0.C.E.D.O.	all pos Othe		ath (Check only on			
ō	Phy or this sral d	٦: T	27. Manner of Death	1 ☐ Inpatient  28a. Date of Injury (Month, Day Ye	2 ER/Outpatient	3LI DOM	4 Nursing I	lome 5 Reside			
0	ding th: Afte	i i	1 Natural 5 Pending 2 Accident investigation		ear) Injury	28c. Injury Work	? ′es 2 □ No	400. D000100 110	W Injury Occi	31160	
<u> S</u>	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	At home, farm, stre	et, factory, office		28f. Location (St	reet and Nun	nber or Rural	Route Number
Š	el or A s after il Direction by	Certification:	4 Homicide	building, etc. (	Specify)			City or Town	, State)		, , , , , , , , , , , , , , , , , , , ,
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours alter death. To the Funeral Director: Attent is certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Ph	/sician: To the best of m	ny knowledge, death	occurred at the time	e, date and place	a, and due to the ca	luse(s) and r	nanner as sta	ted.
	he H in 24 he Fi piete	Medicai	(Check only 2 Medical Exam	iner: On the basis of ex and manner stated	amination and/or inv	estigation, in my op	inion, death occi	irred at the time, da	ate and place	, and due to t	he cause(s)
	To I To I	Σ	29b. Signature and title of certifier			29c. License		29	9d. Date sign	ed (Month, Da	ay, Year)
)	N		Frach Ol			H 5	3419	V	MARCH	1,200	4
	N		30. Name and address of person who o		n (Item 23a) (Type, F	Print)					
			KODNEY DONAMM, 1		relegnath R	LOAD KISI	MC JAN	my 21	5		
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	na Val					
14	ricgiotii	-1.	MAD 0 4 2004	a despect	port plant	s colored					

State of Maryland / Department of Health and Mental Hygiene 2004 06765 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2004 10:40 a<sup>M</sup> Arthur S. Kohne March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death **Examiner** Carroll 405 Pleasanton Road #14 Westminster 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 75 218-22-2900 JAN 25, 1929 Director Marvland Usuat Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mentat Hygene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exactive must be rediffed at once. 1 Yes 2 No Funeral Director Maryland Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 405 Pleasanton Road #14 21157 USA 12. Was Decedent Ever in U.S. Amed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Clothing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ellis Kohne Gertrude Siegel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia S. Kohne/wife 405 Pleasanton Road #14 Westminster. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Metro Crematory, Inc. 3/3/04 Baltimore, MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenseen C. Dawn F. McDonald 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Finat disease or condition End Stuere **Physician** Miserise /Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760 Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year for Month Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Vital Records. funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2X No certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Division of 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After tniury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 2 Accident investigation the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37949 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Stoner Hoe Sut #305. Hereinder Berglaschaustung

31. Date filed (MARay) 24 2004 32 Registrar's Stynature 295 State

DHMH 17 Rev 1/2001

Registrar

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	Α.	_	For Amend Item 23a Registrar	State of Marylan per Dr.,G829, 03	d / Departme /04/Widhb <i>Certifica</i>	nt of Health and te of Death	Mental Hygien Rog. N	2004	06766
1	Physicia /Medic	an al	1. Decedent's Name (First, Middle, Last)		4-01		2. Date of Death Month	ay 2004 c. County of Deeth	3. Time of Death
*	Examin Funeral Director	e,	4a Fadility Name (If not institution, give s  S. Sociat Security Number  230, 09, 57, 81	PI BVI 7. Age (Injuys.)	11e /	er 1 Year   If Under 24 Hrs	8. Date of Birth	Ba	otace (State or Ecreign
	Maryland -f ehow		Usuel Residence of Decedent 10a. State 10b. County	7 10c. City	y, Town or Location	Timor.	e		10d. Inside City Limits
	h with the 23s or 28s	Funeral Director	10e. Street and Number	sbury R	0 101. 2	21708	10g. C	Citizen of What Cou	S.A
036	urs after deat ol', or Items :	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes A ☐ No If Yes, Give Year or Dates:	S. 13. Was Dec If Yes, sp	edent of Hispanic Origin? (Secrify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or items 23a or 28a-f show air injury or other traumatic event, the Modical Exeminar must be notified at once.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e com <i>pleted)</i> College (1-4or 5+)	16a. Decedent's Us (Give kind of v life. DO NOT	vork done during most of wo use retited)		Kind of Business/In	J+ic
Maryland ?	should be filed and Mental Hyg marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last)	Coate	b .	120	me (First, Middle, Majde	ASUR	•
	ss 1 and 2 sho of Health and Item 27 Ie mu r other trauma		19a. Informant's Name/Repationship (Ty	n, Nepher	4705	ss (Street and Number or R	vry KD. 9	SOUTO.	MP 2128
altimore,	permit. Pages 1 Department of H Important: If Iter any injury or oth once.		20a. Method of Disposition  1 ★ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Bonation 5 ☐ Other (Specify)	emoval from State	Place of Disposition (A emetery, crematory of Dulus	morin 2/	Date 20c.	Location - City or To	Own, Stele
Ba	permit. Depart Import any inj		21. Signature of Funeral Service Licens  23a. Part1. Enter the disease, or compli	foully	1460	and Address of Facility (1)  324  Ode of dving such as cardia	G or respiratory arrest	3200	MOZO/ Approximate
	Physician /Medical Examiner	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Social faily list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	Due to (or as a conseq  Hypertension  Due to (or as a conseq	uence of):	IAC Failin			Iniervat Between Onset and Death
O. Box 68760,	ne death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 22 No 9  Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3 □Ectopic			23d. Date of deliv	ery Day Year
ds, P.O.	juires that the d n signed by the lid be detached	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the underlying	cause given in Part I.		use contribute to t	
Vital Records,	The law requires cate has been sign.	Completed					24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
/it	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	lospital:			ath (Check only one)		
ō	Phys this al di	ion: To	27. Manner of Death  1 Neturat 5 Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of tnjury	28c. injury at Work?	Home 5 Residence 28d. Describe how in		(y)
Division	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At he building, etc. (Specif	ome, tarm, street, fact		28f. Location (Street City or Town, Sta		al Route Number,
	the Hospital nin 24 hours a the Funeral npletely filled	edical C		sician: To the best of my kno ner: On the basis of examina and manner stated.					
)	To the within To the comp	Me	29b. Signature and title of certified	40		9c. License number	29d. C	Date signed (Month,	Dey, Year)
	4		30. Name and address of person who co	empleted cause of death (tren		CHEA 14	DER 2108	2	1
	St	ate	31. Date fited (Month, Day, Year) FEB 2 6 2004	32. Registrar's Sona					

State of Maryland / Department of Health and Mental Hygiene 2004 06767 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 1:30 P Feb Gilbert Allan Lewis 28 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner **Baltimore** 10723 Lancewood Rd. Cockeysville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 69 March 15 1934 Director 215-32-5028 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State 10b. County or 28e-f show Exercine must be notified at 1 ☐ Yes 2 No Director Cockeysville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code itеms 23a 10723 Lancewood Rd. 21030 USA by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other treumatic event, the Medical Expir 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Legg Mason Elementary/Secondary (0-12) College (1-4or 5+) Financial Advisors 4 Vice President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marjorie Gilbert 2 Allan Cope Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Jane Lewis/wife 10723 Lancewood Rd., Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Wash. Crematory 3/3/04 Laurel, MD 22. Name and Address of Facility 21. Signature of Funeral S Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael J. Hagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner 10 Sequentially list conditions: if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical as the IF FEMALE: nse use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ò Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. Completed by should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 Yes 20 No certificate 2 □ No 1 Yes or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division 1 Natural
2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation filled in by the within 24 hours after deat To the Funeral Diractor: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital 1 Scentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16006 for ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add George LeRecco.
31. Date filed (Month Park Yolr) 4. 2004 7505 Osler Dr., Suite #502, Towson, MD 7505 ( 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06768 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 3. Time of Death Month **Physician** Paul Linkins 6:00pm 28 Feb 2004 /Medical 4c. County of Deeth Fecility Name (If not institution, give street end number) 4b. City, Town, or Locetion of Death Examiner Charles Co. Nursing & Rehab. LaPlata Charles If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours Yrs.

10d. Inside City Limits

White

WK

4/O Unknown

1 ☐ Yes 2 ☐ No

vivursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Dey, Yeer)

1 ☐ Yes 2 No

Director 28a-f show r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at Peges 1 and 2 should be filed within 72 hours after death with tent of Health end Mental Hygiene. nt: If Item 27 is marked other than "natural", or items 28a or ? Baltimore, Maryland 21215-0020 Depertment of Health end Mental Hygi mportant: If Item 27 is marked other any injury or other traumatic event,

> After this certific funerel director, s efter deeth. I Director: A d in by the fu within 24 hours efter
> To the Funeral Directory Hospitai To the

1 Ves 2 No

5 Pending investigation

MAR 0 4 2004

27. Menner of Death

Natural 2 Accident

1**X**M 2□ F 577-28-3159 Usuel Residence of Decedent June 30, 1923 Maryland 10a. State 10c. City, Town or Location 10b. County Director Maryland Prince George's Brandywine 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3215 Malcolm Rd. 20613 Funeral USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 2/8/1943 If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

15 Yes 2 No Specify:

17 Yes, Give Year or Dates: 12/1/1943 11 Merital Status Black, White, etc. 1 Never Married 2 Married þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Painter/Wall Paper Hanger Residential Painting 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Linkins Mary Jane Edelen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Betty J. Linkins/wife 3215 Malcolm Rd., Brandywine, MD 20613 20a. Method of Disposition

1 

Burial 2 □ Cremetion 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March Maryland Veterans Cemetery 4, 2004 Cheltenham, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Signature of Funeral Service License our Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical PNLLIMONIA Examiner Due to (or as a consequence of): Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pug Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? RTENSION 21440 T Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:

Certification: To 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number au Neme and address of person who completed cause of peath (Item 23e) (Type, Print) AULMELION CT WALDORFMN 20602 PATTEL M

28a. Date of Injury (Month, Dey Year)

State Registrar

31. Date filed (Month, Day, Year)

32. Registrer's Signature

28b. Time of

**DHMH 16 Rev 6/95** 

28c. Injury at Work?

1 Tyes 2 □ No

			1 - For Amend Item 5 per Registrar	r Fit, 6829	MPIY/84	id / Depa idhb <i>Cei</i>	artment of H rtificate of L	ealth and D <i>eath</i>	Mental Hygie	ene2004	06769
	Physici	an	Decedent's Name (First, Middle, L     Alfr		I	LaFratt	ie.		2. Date of Death Month February	y 27, 2004	3. Time of Death 9:45 P. M
	/Medic Examin		4a. Facility Name (If not institution, gi				4b. City, Town, or			4c. County of Deat	
		ш	College View		7. Age (In yrs.	last hirthday)	Fred	lerick If Under 24 Hr	s. 8. Date of Birth	Q Rie	lerick
	Funeral Director		182-16-8743 6. 183-16-8743	1 M 2 □ F	82	Yrs.	Months Days	Hours Mir		1922 N	lary land
	land w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	e-f sh	ctor	Maryland F	rederick			Freder	rick			1∏Yes 2□No
	filed within 72 hours after death with the Maryland Hygiene. viter than "natural", or Rems 23a or 28e-f show wit, I'ra Medical Examinat must be profilled at	al Director	10e. Street and Number 901 Walnut Stre	et			10f. Zip Code	21703		g. Citizen of What Co $\mathbb{U}$ .	untry? S.A.
	tems ?	uner	11. Marital Status	12. Was Dece Armed For	ces?		Was Decedent of Hi f Yes, specify Cuba	spanic Origin? ( n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White	
036	ours after al', or l	Completed by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da			1∐Yes 2⊠No	Specify:		Specify:	White
21215-0036	natur	leted	15. Decedent's E (Specify only highest g			(Give	dent's Usual Occupa kind of work done of DO NOT use retired,	uring most of w	orking 16	6b. Kind of Business/	Industry
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Maryland (	e da b	To Be C	17. Father's Name <i>(First, Middle, Las</i> Anthony LaFratt						ame (First, Middle, Ma PESA	uiden Sumame) Unknown	
Aary	2 should and Men Is marke		19a. Informant's Name/Relationship Barry E. <u>LaFrat</u>				-		Rural Route Number, (	•	
	s 1 and 2 of Health Item 27 other tru		20a. Method of Disposition	•	20b. F	Place of Disno	sition (Name of	1	ederick, Ma	o Location City or	Town State
Baltimore,	permit. Pages Department of the Important: If Ite any injury or of	5 15	1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	ify)	Mt.				2, 2004 I	Frederick,	Maryland
Bal	Depar Impor any ir	9 70	21. Sign the e of Feneral Service Lice	Mal		00021		and Bast	ord Funera		MD 21701
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Specia	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (	Conque	et7're	heart	failus			
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a conseq	juence of):					
, 0	cate be executed physician and the burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (c	or as a conseq	juence of):					
38760,		dicai		d							
.O. Box (	es that the death certifi igned by the attending be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ☐ Feta antat time of d	ildeath 3□	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
<u>α</u>	quires that I n signed by uld be deta	by	Part II. Other significant conditions  Hypertemico	_	ath but not res	ulting in the u	nderlying cause give	n in Part I.	23e. Did toba 1 ☑ Yes	cco use contribute to	the cause of death?
Vital Records,	The law requires that sate has been signed b page 2 should be deta	Completed	" peciphera	e vasco	elac o	liseas			24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
/ital	10 54	Be	25. Was case referred to medical examiner?	. Heesital					eath (Check only one)		
o	Phys rahdii rahdii	: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date o	f Injury	ER/Outpatien	28c. Injury	at Nursing	Home 5 Residence		sity)
sion	Attending Firdeath. sector: After by the funer.	ation	1 Natural 5 Pending 2 Accident investigation	on	h, Day Year)	Injury	Work M 1 □ Y	? ′es 2 □ No		,	
Division of	el or Att s after de if Direct	Certification:	3 ☐ Suicide 6 ☐ Could not determine	286. Place	of Injury - At hogg, etc. (Specif	ome, farm, str y)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funeraf Director: completely filled in by the	edical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	hysician: To the miner: On the ba and mann	sis of examina	owledge, death ttion and/or in	n occurred at the tim vestigation, in my op	e, date and place inion, death occ	e, and due to the cau curred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	MD -			29c. License	number	290	I. Date signed (Month	, Day, Year)
,	, D		- forjue		of death Or	- 02-1 (T	D00	04CC	560	3-01-0	70
_	10		30. Name and address of person who Syed W. HAC	SUE	100 M	nonte	laire A	Je Fre	derick	,MD 2	1701
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 4 2004		egistrar's Signa	duce by	oach!				

State of Maryland / Department of Health and Mental Hygien 2004 067**7**0 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 24, February 2004 12:13 A LIAS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 3/18/1940 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2 KXF 342-32-9411 CHICÁGO, IL Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County itsm 27 is marked other then "naturel", or Items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at 1XXYes 2□No BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5966 GREEN MEADOW PARKWAY 21209 USA Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status I □Yes **2(X**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: BLACK 3 XXVidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: if item 27 is marked other then "na eny injury or other traumatic sven" at 2006. Elementary/Secondary (0-12) College (1-4or 5+) LICENSED PRACTICAL NURSE MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **EUGENE PEEL** LILLIAN BUSSEY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) AVA E. LIAS BROOKER 2908 KINGS GULF DRIVE, ELLICOTT CITY, MARYLAND 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1)XXBurial 2 Cremation 3XXRemoval from State 4 ☐Donation 5 ☐ Other (Specif ABRÀHAM LINCOL NAT. CEM. 3/2/2004 **ELWOOD ILLINOIS** 21. Signature of Funeral Service Li 22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HIGHWAY, SW, GLEN BURNIE, MD 21061 INK Lic # M01148 Approximate Interval Between Onset and Death Enter the disease, d implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cabse (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed use as the burial-transit the attending physician Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 ☐ Yes or Attanding Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Tes 2 ER/Outpatient Medical Certification: To 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 2 Accident 5 Pending 1 TYes 2 □ No death. investigation within 24 hours after deat To the Funaral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide filled To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 24 04 Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary au 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

			for State Registrar	State of M	larylan	d / Depa	artment rtificate	of H	ealth a Death	and M		jiene Z	2004	0677
			1. Decedent's Name (First, Middle, La	•						1	2. Date of Dea	th	Year	3. Time of Death
	Physici /Medio		Josephine Gerald	ine Mart	in						Februar	y 28,	2004	7: 15 a <sup>M</sup>
<b>&gt;</b>	Examir		4a. Facility Name (If not institution, given 1 Taxi Way	e street and number	")		4b. City, T Midd		Location o	of Death		0.0	unty of Deeth timore	
	Funeral Director		217-20-0304	ex 7. A □ M 2☆F	ge (In yrs. 77	last birthday) Yrs.	If Under 1 Months		If Under : Hours		8. Date of Birth (Month, Day July 22	, 1926	9. Birthp Cour Mary	
	and		Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	Od. Inside City Limits
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f ahow any injury or other traumatic event, the Medical Example Trium Item willied at ODGE.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1  Yes 22 If Yes, Give Year or Dates:	? ] No		Was Decede If Yes, specif 1 ☐ Yes 2	fy Cubai	spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: Wh	
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Baltimore, Maryland 21215-0036	hin 72 in "ng Medil	Completed	(Specify only highest gra	de completed) College (1-4or	5+)	(Give	kind of work DO NOT use	done d retired)	luring most )	t of workin	ng			
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Ma	d2sh th and 7 is n traun		19a. Informant's Name/Relationship ( Linda Cousins (Da								<i> Route Number</i> altimor			
e,	1 and Heali tem 2		20a. Method of Disposition	ugiitei )	20b. P	lace of Dispo	sition (Name	e of					on - City or To	
OE.	Pages ent of st: If i		1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif		AI .	emetery, crer n Chur				1arch	1,2004	Balt	imore.	Maryland
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			23a. Park. Enter the disease, or com sinck, or heart failure. List only	plications that cause one cause on each	ed the deat line.	h. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
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П	/Medical Examiner		resulting in death)	Due to (or a	s a conseq	uence of):								
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8760,	icate be executed physician and s the burial-transit	dicai	•	d										
9	ing ph e as th	Med	IF FEMALE:											
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<u>α</u>	The law requires thet the de ate has been signed by the a page 2 should be detached f	y Ph	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying car	use give	n in Part I.		23e. Did tol	bacco use c	contribute to th	ne cause of death?
of Vital Records,	iw requires thei s been signed t should be det	ed by	DM								1 □ Y	es 200	o 3 □ Prob	ably 4 Unknown
000	s bee	Completed	CAD.								24a. Was a	n 24	b. Were auto	psy findings available
Ä	The law	mo:	CHE								autops perform		death?	mpletion of cause of 2□ No
ita		BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only on			
× ×	Physician: r this certific ral director,	To	1 ☐ Yes 2 X No	Hospital: 1 Inpat		ER/Outpatier			4 🗆 1901		ne 5 Reside			1)
n c	After t	on:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time of Injury		Work			8d. Describe ho	ow injury oc	curred	
Division	l or Attending after death. Director: After	Certification:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Ir	njury - At ho atc. (Specif	ome, farm, str y)	M eet, factory,		/es 2□ñ		28f. Location (SI City or Town	treet and Nu n, State)	umber or Rura	I Route Number,
_	Hospita 4 hours Funerel (ely fillec	edical Ce	29a. Certifier  (Check only one)  (Check only one)	ysicien: To the bes niner: On the basis and manner s	of examina	wledge, death	n occurred at vestigation, i	t the tim	e, date and pinion, deat	d place, a th occurre	and due to the ca	ause(s) and ate and plac	I manner as st	ated. the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	A			29c.	License	number		2	9d. Date siç	gned (Month.	Day, Year)
	⊬ 3 ⊢ ŏ		MANA	Lina	MI			200	520	53		02	128k	24
	0		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type,		5 00	-0-0	7 1	0 0	- (A)		2 2
			YAI AI CIM	AYL	23	10	7 1380	$\alpha$ 9	m >	<d< td=""><td>15W1</td><td>im</td><td>1. 00</td><td>11) 2122</td></d<>	15W1	im	1. 00	11) 2122
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	iture								

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene.

			1 - For State Registrar	State of Marylar		tificate of D		Re	g. No.	
	Physici /Medic		1. Decedent's Name (First, Middle, Last, REGINALD MOORE					2. Date of Death Month March	Day Year 3 2004	3. Time of Death 4 9 , 15 AM
	Examin		4a. Fecility Name (If not institution, give Sinai Hospital)  5. Social Security Number 6. Se.	of Baltin x 7. Age (In yrs.	last birthday)		ocation of Death  OPE CIT  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day, 06-28-	4c. County of Deat  N /  Year)  9. Birt	A hplace (State or Foreign
	Director		Usual Residence of Decedent	x <sup>M 2□ F</sup> 46	Yrs.			06-28-	1957   MA	ARYLAND
	n the Marylan r 28a-f ehow	tor	10a. State 10b. County N/A		ty, Town or Loc BAI	ation TIMORE				10d. Inside City Limits 1 Yes 2 □ No
	death with the Maryland me 23a or 28a-f ehow r must be notified at	Funeral Director	10e. Street and Number 2800 REISTERSTO	WN RD		10f. Zip Code	1215	10	g. Citizen of What Co USA	iuntry?
ما 60	⊌ <del>2</del> €	þ	11. Marital Status  1 XNever Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	i	Vas Decedent of His Yes, specify Cuban ☐ Yes 2☐ No	panic Origin? (Sp., Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
Reginald Moore	within 72 hours after iene. then *natural', or Ite	Completed	15. Decedent's Edu (Specify only highest grad		(Give I	ent's Usual Occupat kind of work done du IO NOT use retired)	iring most of work	ing 1	6b. Kind of Business/	Industry
band 2	should be filed within and Mental Hygiene. Is marked other then aumatic event, ILAM	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	laiden Surname)	
Reginald	s 1 and 2 should be filed within the feath and Mental Hygiene. It health and Mental Hygiene at marked other then other traumatic event, It a M	2	ANDREW MOORE  19a. Informant's Name/Relationship (7)  WILHEMINA MOORE				nd Number or Run	al Route Number,	City or Town, State, 2	Zip Code) AND 21223
Re(more,	permit. Pages 1 and Department of Health Importent: If Item 27 any injury or other trongones.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	20b. i Removal from State	Place of Dispos	ition (Name of atory or other place,	1 1	Date 2	Oc. Location - City or	Town, State
Balti	permit. Pa Departmen Importent: any injury once.		21. Signature of Funeral Service Licents	Howell		Name and Address	111		UNERAL H	OME ORE, 21207
	Pnysician /Médical Examiner	er	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	ications that caused the deal ne cause on each line.  a. Heratite  Due to (or as a consect  b. Lef Si Si A	S C   quence of):		ase	or respiratory arre	st,	Approximate Interval Batween Onset and Death 10 mon-ths
68760,	Attending Physician: The law requires that the death certificate be executed redsth.  Gath.  ector: Alter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	quence of):					
	it the death certifi by the attending tached for use as	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fete 4 Pregnant at time of o	eldeath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
ords. P	requires that been signed b	ted by Pl	Part II. Other significant conditions co Insulin depen	1 1 1	-	derlying cause giver nellitu			acco use contribute to	o the cause of death?
al Rec	: The law cate has b							24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
Division of Vital Records, P.O. Box	tending Physician: The leath to the leath tor: After this certificate his the funeral director, page	tlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	Hospital: 1 V Inpatient 2 C 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Other	4 Nursing Ho	h (Check only one ome 5 Resider 28d. Describe hor	nce 6 Other (Spe	cify)
Divisi	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,
¥	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical C		vsician: To the best of my kniner: On the basis of examinated and manner stated.						
	To the vithin	×	29b. Signature and title of certifier  Hay	eg D.O.		1 4	-000		March 3,	2004
9	5		30. Name and address of person who co Hans Ghayee, D.O.	Since Hospital 2004 32. Reference's Sign	m 23a) (Type, 1 of Balt	Print) Figure 24	Ol West Be	ludere A	venue Baltim	1012, Maryland 2121
	Sta Regist	ate rar	31. Date filed (Month Park 1	2004 32. Politicar's Sign	ature	DISHE!				,

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 9 lia March 3:40AM 02 2004 mon /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Dalt MOQLEI MORE
If Under 1 Year If Under 24 Hrs. 10 **Baltimore** GOOD Jamari 1/0 7. Age (In yrs. last birthday) 8. Date of Birth Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Days Min. Hours 69 214-30-3036 Maryland 06-18-1934 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Md **Baltimore** Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23a U.S.A. 21208 Funeral 8205 anita Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced 'naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) rthan College (1-4or 5+) Art Gallery Business Owner 12 should be filed with and Mental Hygier 17 is marked other 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary E. DiMarco 2 Samuel E. Marsiglia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Peges 1 and 2 s iment of Health an tant: If item 27 is Baltimore, Maryland 21208 8205 Anita Road Esther Marsiglia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges Department of Important: If it eny injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) 03-04-2004 Owings Mills, Md Garrison Forest Vet. 22. Name and Address of FacilityLoring Byers Funeral Directors Inc 21. Signature of Funeral Service Licenses 8728 Liberty Road Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath Immediate Cause (Final disease or condition resulting in death) The how Physician /Medical Due to (or as a consequence of): **Examiner** a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to ( as a consequence of) Box 68760, Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, sate has been significant page 2 should be 1 □ Yas 2 □ No. 3 Probably 4 ⊕Winknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No 1 ☐ Yes Division of Vital funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 2 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Tes 2 ER/Outpatient 3□ DOA 27. Mann of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? After t 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Raven Bostevard Baltimore Jolan → **(**) , 601 Bryan 31. Date filed (Month, Pay, Year) MAR 0 4 2004 32. Rigistrar's Signature State Registrar

Pattent facour as Theliva Martin

			Please T	ype or Print in B	Black Ind	lelible Ink	Ensure A	l Copies	Are Legible	
			1 - For State Registrar	State of Maryland	o / Depai <i>Cer</i> t	rtment of F tificate of	leaith and iv Death		lene 200	4 06774
	Physici /Medi	al	1. Decedent's Name (First, Middle, Last) The1ma M.					2. Date of Deat Month Februa	n Day Year	4 0615 M
	Examir Funeral Director	er	213-42-6995	al of Bull	MOre	4b. City, Town, of the City, Town, of the City T	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 11	Year) 9. B	afh  /a  irthplace (State or Foreign Journsy)
	a-f ehow	ctor	Usual Residence of Decedent  10a. State  Maryland  N/A	10c. City	, Town or Local Ba1	ation timore				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ath with the	Funeral Director	10e. Street and Number 4669 Falls Road				209		0g. Citizen of What 0	Country? SA
9036	within 72 hours after death with the Maryland ane. then "neturel; or iteme 23e or 28e-f show ite Medical Examiner was be notified at	by	11. Marital Status  1 Never Married 2 Married  3/3/Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	lf.	as Decedent of H Yes, specify Cuba □ Yes XX No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecrfy Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla I Heaith and Mental Hygiene. Item 27 is marked other then "neturel", or iteme 23a or 28a-1 ehov other treumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) UNKNOWN	cation completed) College (1-4or 5+)	(Give ki life. Do	nt's Usual Occup ind of work done O NOT use retired memaker	ation during most of worki f)	ng	16b. Kind of Busines Own H	
Maryland	2 should be filed withir and Mental Hygiene. is marked other then eumatic event, the M.	To Be (	17. Father's Name (First, Middle, Last) Meneth Dorman Figh	ıtmaster			18. Mother's Name unknown	(First, Middle, N	faiden Sumame)	
	1 and 2 sho Health and tem 27 is m		19a. Informant's Name/Relationship (Type Willard R. Cox	(Son)	2438 1	Lodge Fa	rm Road	Edgemer	City or Town, State, e, Maryla	nd 21219
Baltimore,	Page nent o int: If iry or		20a. Method of Disposition  1 Burial XXCremation 3 Re  4 Donation 5 Other (Specify)	emoval from State Ba1	timore-	atory or other place -WAshing	ton 3/2	/2004	Laure1,	Maryland
Bal	permit. Departn Imports eny inju		21. Signature of Fineral Service Ligense	apula		oor rarr	s roau	partimor	Home, In e, Maryla	nd_21211
	Physician /Medical		23a. Pan-Enfer the disease) or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cluse on each line.  Due to (or as a consequi	LARMO	UKSCL	CARF	-~ ( C C	105 8	Approximate Interval Between Onset and Death
	Examiner	mlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque		otic o	CARSION	ASCU D	ISEASI	
68760,	icate be execut physician and s the burial-tran	Еха	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
O. Box	the death certify the attending ched for use a:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	lc. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3 □E	ctopic pregnancy Other (specify)			23d. Date of de Month	l livery Day Year
Records, P.	quires tha n signed ald be del	by	Part II. Other significant conditions cont	ributing to death but not result	iting in the und	erlying cause give	en in Part I.			o the cause of death?
al Reco	The ate h page	Completed						24a. Whas an autopsy perform	prior to	utopsy findings available completion of cause of 2 2 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital: 1  Inpatient 2  E	P/Outertiest	2□ DO A Othe	26. Place of Death			
on of		-	27. Manner of Death  1 Netural 5 Pending		R/Outpatient 28b. Time of Injury	28c. Injury Work	at 2	8d. Describe how	nce 6 Other (Spe v injury occurred	icify)
Division	tal or Attending s after death. al Director: Atte	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stree			81. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital within 24 hours a To the Funaral C completely filled i	edical (	29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examine	cian: To the best of my know er: On the basis of examination and manner stated.	dedge, death o	occurred at the time stigation, in my or	e, date and place, a pinion, death occurre	nd due to the car d at the time, da	use(s) and manner a le and place, and du	s stated. e to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	n 60		29¢. License	number	29	d. Date signed (Mon	h. Day, Year)

State Registrar

1

DHMH 17 Rev 1/2001

RD. ZIZIS

(OHEN, HI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(31. Date file Appth, Day, Year)

4. 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 2004 06775 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 4:35 P Mary Elizabeth Mathias <u>February</u> 29. 2004 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklinwood Center Rosedale Baltimore County 8. Date of Birth (Month, Day, Yeer) Nov. 27, 19 If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🏋 F Yrs. 219-16-6299 94 Nov. 1909 Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan and of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28e-1 show ury or other traumatic event, the Marylan Examiner must be notified at 1 Yes 2 No 0ver1ea Baltimore Co. Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 5906 Farmview Avenue 21206 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2x TxNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: Be Completed by white 3√ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Admin. Timekeeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James Thomas Howe Mary Alice Fantom 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Virginia L. Stevens (Daughter) 5906 Farmview Avenue Overlea. Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or Baltimore National Cem. 3/3/04 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signatura Ameral Service 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 37631 Falls Road Baltimore, Maryland Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21211 Approximate Interval Between Onset and Death Immediate Cause (Final Therosc Cov Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Wes decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknow à signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performad: has 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After Injury or Attending 1 Natural 2 Accident 5 Pending after death.

I Director: After director of the furnishment of the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide hours after within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of eartifier 204 131 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Rahnama, 9512 Harford Road Parkville, Maryland MD 31. Date filed (Month, Day, Year) MAR 0 4 2004 32. gistrar's Signature State Registrar

06776 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:15AM **Physician** 28 Masimer 040 W /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 4910 PENNINGTON AVE. CURTIS BAY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) 5. Social Security Number **Funeral** 10XM 2□F MARYLAND 76 218-22-7063 4/5/1927 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f show the Medical Examiner must be notified at 1XXYes 2 ☐ No MARYLAND CURTIS BAY Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4910 PENNINGTON AVE. 21226 USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 1949-52 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE ģ 3 ☐ Widowed 4 🛣 Divorced permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene Important: If Itam 27 Is marked other than "natural any injury or other traumatic event, the Mudical Fix 2005. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOBILE CAR SALESMAN 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be UNKNOWN ELSIE ANDERSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NANCY CHAMBERS DAUGHTER 971 BENNETT RD. ARNOLD, MARYLAND 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition tXXBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS 3/3/2004 CROWNSVILLE, MD 21. Signature of Funeral Service Licensed 22. Name and Address of Facility
SINGLETON FUNERAL HOME, P.A. 3 1 SECOND AVE.S.W. GLEN BURNIE, MD 21061 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PREDIMONIA **Physician** /Medical Due to (or as a consequence of) 5 Ears PULMONARY FIRROSIS Examiner IdIOPATHL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea:
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Dav lor in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ þ ARTERY DISEASE 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETES autopsy performed? Yes 2 No page 2 1 Yes 2 No 1□ Yes certificate the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 s after dea.
rel Director: After u.
nv the funeral di this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide thin 24 hours at the Funerel D mpletely filled in Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 2 13355 04 JUNIOR ATTENDING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Greene Street
32. Registra BALTIMONE VANC Baltimone Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 4 2004 Poster Registrar

			1 - State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artmen rtificat	t of Health e of Death	and N		gien <b>g</b> Reg. No.	-	06777
	Physici		1. Decedent's Name (First, Middle, Last	GucoD					2. Date of De. Month	Day	Year	3. Time of Death
No.	/Medio		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Location	of Death	FEBRUA		County of Deat	<u>'                                    </u>
	Funeral Director		5. Social Security Number 6. Se 249-88-0119		last birthday) Yrs.		1 Year   If Under Days Hours	r 24 Hrs.	8. Date of Birt (Month, Da	th v. Year)	9. Birtl	DE LOUNTY  Inplace (State or Foreign  unity)  H CAROUNA
	land		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
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	or 28	Director	10e. Street and Number	CON ATTE		10f. Zip				10g. Citi	zen of What Co	untry?
	leath v		3633 EDMOND	12. Was Decedent Ever in U	S 13 V	Was Decer	21229		ecify Yes or No		USA 14. Race - Amer	ican Indian
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene stem 23 is marked other then "natural", or items 23a or 28a-f show other trenmatic event, the Medical Evanties must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		fYes, spec 1 ☐ Yes	dent of Hispanic Or offy Cuban, Mexica No Specify		Rican, etc.)		Black, White	
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	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (T) LEOLA MAGWOOD	WIFE		•	(Street and Numb DMONDSO					
Jre,	of Health item 27		20a. Method of Disposition	20b. F	Place of Dispos	sition (Nan	ne of		Date		cation - City or T	
altimore,	Pages Iment of Lant: If it jury or o		15 Burial 2 □ Cremation 3 □ F • 4 □ Donation 5 □ Other (Specify)	A A	RBUTU	S PA	RK	3/3,			BUTUS,	
Bai	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other once.		21. Signature of Foneral Service Lynns	ef	22	T30	EP BROS 0 EUTAW	· FU	UNERAL BALTO	HOM O. M	ME P.A. MD. 212	217
П			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the deat ne cause on each line.	h. Do not ente	er the mod	e of dying, such as	s cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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o Î	ficate be executed physician and is the burial-transit		that initiated events resulting in death) Last	c Due to (or as a conseq	uence of);							
8760	ate be hysicia the bur	dlcal		d								
Φ	eath certific attending p	/Mec	IF FEMALE:	23c. If yes, outcome of pregna	incv				_		10d Date of date	
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סר	ding Phy h. After this funeral d	<b>—</b>	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury at Work?	-	me 5 🗌 Resid 28d. Describe h			<i>(y)</i>
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Division of	To the Hospital or Attending within 24 hours after death.  To the Funerel Director; After completely filled in by the funer	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory	, office		28f. Location (S City or Tow	treet and n, State)	l Number or Rur	al Route Number,
	Hospi 24 hou Fune Fune	edical	29a. Certifier 1	sicien: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred a estigation,	at the time, date an in my opinion, dea	nd place, a ath occurr	and due to the c ed at the time, o	ause(s) a late and	and manner as s place, and due t	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			1	License number				signed (Month,	
	,/		1	S. RAO. M. C			4340			EBN	LUANY	26,2004
	9		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, F	Print) /C	-S-RAO	1.1.	. O	0 2	1177	
	Sta	te	31. Date filed (Month, Day, Year)	A Registrar's Signa	ture			30 00			2	
	Registr		MAR 0 4 2004	Elever H.	Anna	6. 0						

		1	_ State	State of Maryland / Department of Health and Mo	ental Hygiene 2004 06778
			1. Decedent's Name (First, Middle, Last)		2. Date of Death  3. Time of Death
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	death v	Funeral Director	11. Marital Status	Was Decedent Ever in U.S.     Armed Forces?  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificicompletely filled in by the funeral director,	Medical	29a. Certifier Check only 2 Medical Exami	sician: To the best of my knowledge, death occurred at the time, date and place, ner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, date and place, and due to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	- A Herding 29c. License number  1000 Physician D41699	29d. Date signed (Month, Day, Year)
	2		30. Name and address of person who co		ILL, M.D. Union Memorial
	2		31. Date filed (Month, Day, Year)	32. Registrar's Signature	10, 21218 140spital
	St Regist	ate rar		2004 Laner & Spake	

		1. Decedent's Name (First, Middle, L.	ast)							2. Date of Death Month		V	3. Time of Dea
Physicia /Medica	_	KURT	A		MISEK					FEBRUARY	Day 26, 2	Year 1004	1330
Examine		4a. Facility Name (If not institution, gi	ve street and number	)		4b. City,	Town, or	Location of	of Deeth		_	ounty of Death	)
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uneral		5. Social Security Number 6. 209.52.6676	Sex 7. A 1XX M 2 ☐ F	ge ( <i>in yr</i> s. 46	last birthday, Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Dey,		9. Birth	place (Stete or For intry)
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ral', or itema 23a or 28a-f show Examiner mast be notified at	Director	10e. Street and Number				10f. Zip				10		n of What Cou	intry?
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% P	Medical	IF FEMALE:	d										wellen colucta
detached for use		23b. Was decedent pregnant in the past 12 pronths?  1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	I death 3	]Ectopic pr ] Other (sp					23d	. Date of deliv Month	ery Day Year
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	lend	ŀ	10a. State 10b. County		10c. City, To	wn or Loc	cation				10	d. Inside City Limits	
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	h the	Funeral Director	10e. Street end Number		1		10f. Zip Code		10	g. Citizen of V	Vhat Count	ry?	
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	dea T	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. V	Vas Decedent of Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-		e - America k, White, e		
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5	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16	a. Deced (Give I	ent's Usual Occu	upetion e <i>during</i> most of work red)	ting 1	6b. Kind of B	usiness/Indi	ustry	
121	vithin Pan Pan	ğ.	Elementary/Secondary (0-12)	College (1-4or 5	i+)					A DMV			
7	filed within Hygiene. ort, the M		17. Father's Name (First, Middle, Last)	2		MITTI	TARY IN	TELLIGENCI	e (First, Middle, Ma	ARMY	ne)		
ano	& ta & y	o Be	LOUIS			MTIE	TZKY	MARY	0 (1 1101, 11110010, 1111		KNOWN		
Maryland	2 should be filed within end Mental Hygiene. Is marked other than aumatic event, I'm M	۲	19a. Informant's Name/Relationship (7	Type, Print)	19			et and Number or Rui	ral Route Number.			Code)	
Z	2000	Ĭ	RUTH MILLS / WIF	•	411			CK COURT .		-			
ē,	of Heelth Item 27	1	20a. Method of Disposition		20b. Place	of Dispos	sition (Name of patory or other pl	T.		c. Location -			_
Ē		- 1	1 M Burial 2 □ Cremation 3 M 4 □ Donation 5 □ Other (Specify	Removal from State			I NATION		3/3/04	FT. MY	FRS.	VA	
Baltimore,	P. Pragart	1	21. Signature of Funeral Service Licen	see/ 1.2	C		Name and Add		OL LEVINS				_
œ	Ped diministration of the diministration of	1	* SUMMOVIA	ITAH.		8	900 REI	STERSTOWN					
	130 1313	7	23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused	the death. Do	not ente	or the mode of dy	ring, such as cardiac	or respiratory arres	st,		Approximate Interval Between	
- Aller	Physician		andar, or mount tandro. Electiony	5110 54350 511 54311 III							1	Onset and Death	
7	/Medical Examiner	- 1	Immediate Cause (Final disease or condition	a INANIT	ION						;		
		_	resulting in death)		Due to (or es a	a consequ	uence of):				1		
7	nsit	Examiner	•	b	_		VE. 12.1				- 1		_
,	law requires that the death certificate be executed as been signed by the attending physician and 3.2 should be detached for use as the bunal-transit	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a	i consequ	iet.ce cty.				1		
68760,	ysicia ysicia		that initiated events	c	Due to (or as a	consequ	ience of):						
89	tifica ng ph as th	Medicai	resulting in death) Last		•		·				İ		
Вох	attendir	and		d									_
	t the dea by the at tached fo	Physician/	Part II. Other significant conditions co	ontributing to death b	ut not resulting	in the un	derlying cause g	jiven in Part I.	23b. Did tob	acco use co	ntribute to	the cause of death?	?
P.0	d by detacl								1 🗆 Yes	2□ No	3 Probe	ably 4 🛣 Unknown	n
JS,	res that signed t	2							Oda Wasan		24h Wes	re eutopsy findings	-
Ö	v require been si should	e e							24a. Was an performe	autopsy ed?	avai	lable prior to	
<b>3e</b>	has a	Completed								_		eath?	
a	ician: The l certificate harector, page		OF Was seen selected to a discussion						1	2 <b>X</b> No	1 🗆	Yes 2□ No	
of Vital Records,	Physician: r this certific and director,	10 126	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 ☐ Inpatie	nt 2 ER/C	Jutnationt	3□ DOA O	ther:	h (Check only one) ome 5 🗆 Residen		or /Canaihi	HUGDICE	
	Phys eral d		27. Manner of Death	28a. Date of Inju (Month, Da		Time of	28c. Inju		28d. Describe how			HOST TOE	-
<u>o</u>	Attanding or death.  Sector: After by the fune	atio	1 Maturel 5 ☐ Pending 2 ☐ Accident investigation	(Worth, Da)	( real)	Injury		Yes 2□No					
Division	Atta er der ecto by th	Certification:	3 ☐ Suicide · 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injuding, etc		farm, stre	et, factory, office	•	28f. Location (Stre City or Town,		er or Rural	Route Number,	_
	rs after all Dir			J	(-,, )								
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical		vician: To the best of liner: On the basis of and manner sta	exemination a								
	Withi To the	Σ	29b. Signature and title of certifier				29c. Licer	nse number		d. Date signer	(Month, D	ay, Year)	
				1-			1)	4372	-	2/	241	104	
	10		30. Name and address of person who								. (		
	Stat	9	DR. TARIQ MAHMO 31. Date filed (Month, Day, Year)		<b>DULANEY</b> er's Signature	VAL	LEY RD.	TIMONIUM	, MD 2109	93	-		
	Registra		MAR 04 2		galance	15	Som	ekist "					

FEBRUARY 24, 2004

HARRY MILLS

		1 - For State Registrar	State of Man	yland /		artmen tificate				R	leg. No.	104	0678
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last)     HELEN C. MERSK     4a. Fecility Name (If not institution, give s. MERCHELEN C. MERCHELEN	Street and number)					Location of	M	Date of Dea Month IARCH 1	Day	Year of Death	3. Time of Death 7:00 A M
Funeral Director		WESTLEY NURSIN  5. Social Security Number 219-30-0874  Usual Residence of Decedent		n yrs. last i	birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. 8. Min. J	Date of Birth (Month, Day IULY 31	Year) 1915		olace (State or Foreign http://
he Maryland 28e-f ehow ctiffed at	ector	10a. State 10b. County  MD HARFOR  10e. Street and Number		Oc. City, To	BEL		Code				I0g. Citizen of \		0d. Inside City Limits 1 ☐ Yes 2 ☑ No
hours after death with the Maryland turel', or Iteme 23a or 28e-f ehow at Exartinet be rediffed at	Funeral Director	1439 EAGLE RIDGE R	UN 12. Was Decedent Eve Armed Forces? 1 □ Yes 2 □ No	er in U.S.		Was Deced	lent of Hi cify Cuba	spanic Ori n, Mexicar		fy Yes or No- can, etc.)	U	S.A. Se - Americ ck, White,	an Indian,
within 72 hours aft ene. then "naturel", or ne Wedlest Ever.	Completed by	3 N Widowed 4 □ Divorced  15. Decedent's Edu (Specify only highest grade) Elementary/Secondary (0·12)		16	Sa. Deced	1 ☐ Yes : dent's Usua kind of wo DO NOT us	al Occupa	luring mos	t of working		Specify 16b. Kind of B	usiness/Ind	dustry
id be filed with ental Hygiene ked other the ic event, the	To Be Com	8TH  17. Father's Name (First, Middle, Last)  KONSTANCIA CELMER			M	IANAGE	ZR			First, Middle, NE KROI	K-MAR' Maiden Suman PALSKI		AIL
and 2 shoui lealth and Me m 27 is merl her treumati	T	19a. Informant's Name/Relationship (Ty CONSTANCE SCANLAN	rpe, Print) I/DAUGHTER		1439	EAGI	E RI	DGE		BEL AI	r, City or Town, R, MARY	LAND	21014
ermit. Pages 1 a epartment of Hes aportent: If item ny injury or othe		20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	removal from State	20b. Place ceme ST. S	STANI 22	SLAUS . Name an	CEN	1.	3/4/04	4 RLES S	BALTIMO	ORE, R & S	MARYLAND ON, INC.
Physician /Medical		23a. Part   Enter the disease, or compleshoot or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	ications that caused the cause on each line.  END - STV.  Due to (or as a cause)	165	not ent	er the mod	e of dyin	g, such as	cardiac or r	respiratory arr		ICT LAIN	Approximate Interval Between Onset and Death
te be executed ysician and with the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence o VAS	CUR		~	ULAR LASE		CIDEN	175		YCARS YLARS
death certificate be e e attending physician od for use as the buri	cal	23b. Was decedent pregnant	d	pregnancy		C AK		VASO	YLM	e Di		te of delive	VLARS  ory  Day Year
0 0 2	by Physician/Med	in the past 12 months? 1  Yes 2 No 9  Unknown  Part II. Other significant conditions co	4 □ Pregnant at tim 9 □ Unknown  ntributing to death but r			Other (sp		en in Part I		23e. Did to			ne cause of death?
aw requi as been s 2 should	Completed b								_	1 ☐ Y 24a. Was a autop perfor	sy	3 Prob Were auto prior to co death?	psy findings available mpletion of cause of
sicien: certifica irector, p	To Be	1 Yes 200 No	Hospital: 1  Inpatient		Outpatier			er: 4 Nu	ırsing Home	1 ☐ Yes Check only or 5 ☐ Resid	2 No	1 □ Yes ner (Specif	2 No (y)
i or Attanding Physician: after death. Director: After this certifica in by the funeral director, I	Certification:	27. Manger of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Y 28e. Place of Injury building, etc. (	r - At home	b. Time o Injury , farm, sti	М		Yes 2□	No		treet and Numl		ul Route Number,
To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in I	edical		sician: To the best of a iner: On the basis of ex and manner state	xamination						at the time, o	date and place,	and due to	the cause(s)
To the within 2 To the Complet	M	29b. Signature and title of certifier  30. Name and address of person who certifier	Volgn	th (Item 23	a) (Tvne		D.	194	25		29d. Date signe	ed (Month, — ZC	21209
Sta Registr		ROBERT E, ROB 31. Date filed (Month, Day, Year)	7 M.D 7	22/1	W.	RoGI	PS	AVO	E-BI	AL MMO	RE, N	D.	21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1

ian	1. Decedent's Name (First, Middle, Las	t)	-			2. Date of Deat Month	Day Yea	3. Time of Death
ian ical	DAJAH	McKOY		# 05 T-			RY 27, 200	
ner	4a. Facility Name (If not institution, give JOHNS HOPKINS HOS				or Location of Dea ORE CITY		4c. County of De	A A
	5. Social Security Number 6. Social Security Number 1		s. /ast birthday)  1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth	Year) 9. B	hirthplace (State or Foreign Country) ARYLAND
	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
ţo	MARYLAND N/A		BALTI	MORE				1XXYes 2 ☐ No
Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
a	3611 BOWERS AV	E APT A			207		U.S.A.	
by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Marned  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 X Xo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No		Specify Yes or No- rto Rican, etc.)	Black, Wh	nerican Indian, nite, etc. LACK
	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busines	ss/Industry
Completed	(Specify only highest gra	de completed) College (1-4or 5+)	life.	kind of work done DO NOT use retire	d) most of wo	inning		
	N/A			N/A	10 14-15-1-1	ma /First Adiable 1	N/A	
Be	17. Father's Name (First, Middle, Last)					me (First, Middle, M INE MCKOY		
0	CHRISTOPHER JEFF  19a. Informant's Name/Relationship (7)		19b. Mailir	ng Address (Street			City or Town, State	, Zip Code)
	Christine McKoy/							ryland 21207
	20a. Method of Disposition  1Ă Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify  21. Signatur uneral Service	Removal from State  ()  WC	Place of Dispo cemetery, cres	esition (Name of matory or other plan CEMETERY	се) 03-	Date 05-04 W	20c. Location - City o	or Town, State  MARYLAND
	1 mills	-		LLIAM C .206 W NO			FUNERAL HO	ME P.A.
ler	23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a.  Due to (or as a conse	IP/E	er the mode of dyin		c or respiratory arre	əst,	Approximate Interval Between Onset and Death
ledical Examiner	cause. Enter Underlying Cause (Undease or injury that initiated events resulting in death) Last	cDue to (or as a conse	equence of):					
Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√2 No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)	y		23d. Date of d Month	elivery Day Year
۵	Part II. Other significent conditions of	ontributing to death but not re	esulting in the u	nderlying cause giv	ren in Part I.	23e. Did tob		to the cause of death?  Probably 4 □Unknown
Completed						24a. Was a autops perform 1X2 Yes 2	y prior to ned? death?	
Be	25. Was case referred to medical examiner?	Hospital:		Ott	ar	ath (Check only on		
2	1   Yes 2   No  No  No	1X Inpatient 2	ER/Outpatier 28b. Time of	IL 3LI DOA	4   Nursing I		ence 6 Other (Sp ow injury occurred	pecify)
Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	2/24/0 4	Unlenter Unlenter	M 1□	Yes 2 No	Subject	t struck	Rural Route Number
	4 Homicide determined  29a. Certifier 1 Certifying Ph	building, etc. (Spec	A+ ly	one	me, date and plac	APT. A, GO	reet and Number or In. State) 36 II Bl	MD
edical		niner: On the basis of examinand manner stated.						
Me	29b. Signature and title of certifier  Ray Levelle	is Ali		29c. Licens			9d. Date signed (Mod EBRUARY 2	
( H		completed cause of death (Ite	em 23a) (Type,	Print)				
	2/13/UCAL 31. Date filed MARY, 0av, 4 eac) 004				nn Stree	et, Baltin	nore, Mary	land 21201

		•	For State Registrar	State of M	laryland / Depa	artment of Hertificate of E	ealth and M Death	Re	g. No.	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Clare.	nce Albe	rt Naill			2. Date of Death Month March	Day Y	3. Time of Death 9:44am
	Examin	_	4a. Facility Name (If not institution, give : Sinai Hospita	Λ		4b. City, Town, or Baltime	me M	D	4c. County of Baltry	move
	Funeral Director		5. Social Security Number 6. Security Number 218–44–4388  Usual Residence of Decedent	7. A M 2□F	ge (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	ff Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 26,	Year) 1943	e. Birthplece (State or Foreign Country) Maryland
	Maryland -f show	tor	10a. State 10b. County Maryland N/A		10c. City, Town or Lo		ltimore			10d. Inside City Limits  XXYes 2□No
	with the 3a or 28a I be nuti	i Direc	10e. Street and Number 3435 Ash Street			10f. Zip Code	21211	10	Og. Citizen of Wh	at Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumatic event, I'm Medical Exam narmon the collified at once.	y Funeral Director		12. Was Deceden Armed Forces 1 Tes A If Yes, Give Year or Dates	(No	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes XX No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. white
21215-0036	hin 72 hour a. "natural" Medical Ex	Completed by	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece (Give life.	dent's Usual Occupa kind of work done d DO NDT use retired)	uring most of work	ing	16b. Kind of Busin	ness/industry
N	be filed withintal Hygiene. Id other than	Be Con	8 17. Father's Name (First, Middle, Last)		San	itation E	18. Mother's Name			re City
Maryland	2 should to and Ment Is marked raumatic e	ို	Arthur Naill, Sr.  19a. Informant's Name/Relationship (Ty			ng Address (Street a	nd Number or Run		City or Town, St.	
	permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr <u>once</u> .		Rose M. Martin  20a. Method of Disposition  XXD Burial 2 Cremation 3 F	Siste	20b. Place of Dispo cemetery, cre	Weldon Average of matory or other place	e)	Date 2	20c. Location - Ci	100
Baltimore,	permit. Pa Departmen Important: any injury		4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licens	ee /	B	ove Cemete 2.Name and Addres urgee-Hens 631 Falls	s of Facility	Funeral		, Maryland nc. vland 21211
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or comb shock, or heart feliure. List only in immediate Cause (Final disease or condition resulting in death)  Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Mala Due to P	ed the deeth. Do not en line.  naut Ven s a consequence of):	ter the mode of dying	such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death I hr Is years
k 68760,	ertificate be executed ling physician and e as the burial-transit	edical	(SEEMALE	d	s a consequence of):		7			0
.O. Box	requires that the death certifi een signed by the atlending I hould be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
<u>α</u>	quires that n signed by	Ď	Part II. Other significant conditions co	ntributing to death	but not resulting in the t	inderlying cause give	on in Part I.	23e. Did tob		ute to the cause of death?  Probably 4 □Unknown
Vital Records,	elaw hasb ye 2 s	Completed						24a. Was ar autopsy perform 1 Yes 2	ned?   dea	ire autopsy findings available or to completion of cause of ath?  Yes 2 No
ita	eiclan: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one	9)	
on of V	ling Phye	ပ္	1 ☐ Yes 2 No	28a. Date of fn (Month, D		of 28c. Injury Work	4   Nuising Ho	ome 5 Reside 28d. Describe ho		· · · · · · · · · · · · · · · · · · ·
Division of	To the Hospital or Attending within 24 hours efter death.  To the Funeral Director: Afte completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of I building,	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office		28f. Location (Str City or Town	reet and Number , State)	or Rural Route Number,
	he Hospit in 24 hour: he Funera pletely fille	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the besiner: On the basis and manner	st of my knowledge, deal of examination and/or in stated.	vestigation, in my op	oinion, death occur	red at the time, da	ate and place, and	d due to the cause(s)
	To the To the Comp	Z	29b. Signature and title of certifier	l		29c. License		29	3/1/04	Month. Day, Year)
	D		30. Name and oddress of person who of Leffrey E. Sel		death (Item 23a) (Type W. Belveden		Suite 50	8 Balt	imore M	D 21215
	Sta Regist		31. Date filed (Magh Pey, Year) 20	04 32 33 egis	strar's Signature	ascie)				

			For State Ragistrar	State of	Maryland	d / Depa <i>Cei</i>	artment of H	lealth a Death	and M	ental Hyg	giene Reg. No.	200	06784
			1. Decedent's Name (First, Middle	, Last)						2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic		Mary Eliza	beth Owens						March		2004	6:46 p M
$\rightarrow$	Examin		4a. Facility Name (If not institution	, give street and numb	per)		4b. City, Town, or	Location of	of Death			ounty of Deat	
			Glen Meadows				Glen	Arm If Under	24 Hes 1	0.0-1(8:4)		1timor	
	Funeral		5. Social Security Number	6. Sex 7.	. Age <i>(In yrs. Ii</i> 96	ast oirtnaay) Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day Aug. 29	190	7 Ba	hplace (State or Foreign untry) Ltimore
	Director		215-01-4683 Usual Residence of Decedent	721						nug. 23	,,100	/ Da.	ICINOLE
	yland pow		10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits
:	Mar.	ţō	Maryland Baltin	more		Glen	Arm						1 ☐ Yes 2 ☐ No
	or 284	ire	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Co	untry?
	23a	Funerai Directo	11630 Glen A				2113					S.A.	
	tems tems	nue	11. Marital Status	12. Was Deced Armed Ford	es?	5. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Ori in, Mexicar	igin? (Spe n, Puerto	cify Yes or No- Rican, etc.)	14	<ol> <li>Race - Ame Black, White</li> </ol>	
36	rs aner death with the Marylar ", or items 23a or 28e-f show carring munt be notified at	by Fi	1 Never Married 2 Marr 3 XXVidowed 4 Divorced	ied 1 ☐ Yes 2 If Yes, Give Year or Dat			1 ☐ Yes 2 📆 🐪 o	Specify:			5	Specify: Wh	ite
2-0036	be lied within /z nouts after death with the Maryland tal Hygiene. Ad other then 'naturel', or items 23a or 28e-f show event, the Madical Examinar must be notified at	edt	15. Deceden		93.	16a, Dece	dent's Usual Occup	ation			16b. Kind	d of Business/	
5	n n n	Completed	(Specify only highes	st grade completed)	lor 5 .\	(Give	kind of work done of DO NOT use retired	during mos	it of worki	ng			,
212	r the	Ē	Elementary/Secondary (0-12)	College (1-4	tor 5+)	Во	okkeeper				St	cone Co	mpany
פַ	e filed wi if Hygien other th	BeC	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle,	Maiden S	iumame)	
<u>a</u>	should be and Mental marked o umatic eve	ToE	William			Goldst	raw	С	lara	Belle 1	Larki	in	
Maryland 2121	s 1 and 2 should if Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relations				ng Address (Street				-		
	and ealth m 27		John R. Owens J	r. (son)	001 51		Vindemere			Phoenix			
altimore,		- 33	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from St	ate		esition (Name of matory or other place					ation - City or	
<u>E</u>	tment tent:	- 6	• 4 □ Donation 5 □ Other (S		Gre		nt Cremate						laryland
Ba	permit. Page Department of Importent: If any Injury or once.		21. In ature of Funeral Servic	Jon In M	Dunk	2	Part of Addition 1988	i-Wie	defe.	ld F.H. Baltim	Inc.	Marulan	d
	20244		23a. Part1. Enter the disease, or	complications that car	used the death							ary ran	Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on ea	ch line.		RCINO					00	Interval Between Onset and Death
4	nysician /Medical		disease or condition resulting in death)	a. Dia to /o	r as a consequ		KCINU	MH	C)	1111=	900	010	2 moning
	Examiner			0,010 (0	as a consequ	161106 01).							
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (o	r as a consequ	ience of):							
	outed id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G									
0,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (o	r as a consequ	ience of):							
8760,	ate be executed hysician and the burial-transit	Physician/Medical		d					-				
X	as p	Mec	IF FEMALE:	23c. If yes, outco	ama of progna	no.							
Вох	ath c	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 ∐ Fetal ntattime of de	death 3[	Ectopic pregnancy Other (specify)	,			23	3d. Date of deli Month	ivery Day Year
o	0 0 2	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknov		an st	Other (specify)						
۳.	law requires that the death cer as been signed by the attendin 2 should be detached for use		Part II. Other significant condition	ons contributing to dea	ith but not resu	ılting in the u	nderlying cause giv	en in Part I	ı.	23e. Did to	bacco us	e contribute to	the cause of death?
Sp	urres sign ld be	d by	HYDRO	NEPH	1205	15				1 🗆 Y	es 2 🕽	KNo 3□Pr	obably 4 Unknown
Records,	w req	Completed	(.D.P.	D	,					24a. Was a	an	24b. Were au	topsy findings available completion of cause of
Re	The lavate has	mo	HYDER	TENS	INN					autop perfor 1 Tyes	med? 20%No	death?	2 No
	ilcien: Th certificate rector, pag	0	25. Was case referred to medica		( 0			26. Place	e of Death	(Check only or		1 103	2.3.10
<u> </u>	Attending Physicien: r death. ector: After this certific by the funeral director,	ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 □ In.	patient 2	ER/Outpatie	nt 3 DOA Oth	er: 4 Nu	ursing Ho	ne 5 ☐ Resid	ence 6	Other (Spec	cify)
ō	ding Phys h. After this funeral dii	L:U	27. Manner of D-ath 1 Natural 5 □ Pendir	28a. Date of (Month	Injury Day Yeer)	28b. Time o	f 28c. Injur Wor	y at k?		28d. Describe h	ow injury	occurred	
<u>S</u>	ottsndin death. ctor: Af y the fur	atic	2 Accident investi	gation				Yes 2 □	No				
Division of	or Attancatter death	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	Lined 200. Flaue	of Injury - At ho g, etc. <i>(Specil</i> y	me, farm, st	reet, factory, office			28f. Location (S City or Tow		Number or Ru	iral Route Number,
	urs af	Ce			t l	1-1 1			1 -1				
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate h completely filled in by the funeral director, page	ledical	29a. Certifier Certifyir (Check only one) Certifyir	ng Physician: To the t Examiner: On the bas and manne	sis of examinat	wiedge, deai tion and/or in	n occurred at the tir vestigation, in my o	ne, date ar pinion, dea	ath occurr	ed at the time, o	date and p	olace, and due	to the cause(s)
	ithin (	Me	29b. Signature and litle of certifie		/		29c. Licens	e number			29d. Date	signed (Monti	h, Dey, Year)
	⊢ ≯ ⊢ ŏ			RAMAI	JA-Ma	TALAN	In any	17	225	?	() -	3/0=	3/04
	10		30. Name and address of person						1	6		0 4 -	- 2 0 4
	10		KAMANA (	SOPALA	-NM	D	LE KO	LLIN	16 U	2085 KO1	425	JAU1/1	na12= 2/228
	Sta		31. Date filed (Month, Day, Year)		gistrar's Signa	•	. 4	1		10-			
	Regist	rar	l v	IAR 0 4 200	4 5	apera		spa	w	=			

State of Maryland / Department of Health and Mental Hygiene? [] [] [ For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death Decedent's Name (First, Middle, Last) Year **Physician** 3.00 AM MARCH 01 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deet **Examiner** Cottoner 24 Hrs. Date of Birth (Month, Day) 9. Birmplece Country) If Under (State or Foreign (In vrs. last birthday) **Funeral** Months Days 1 M 2 Z Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heatith and Mental Hygiene.
ant: If item 27 is marked other than "naturel", or items 23e or 28e-4 ehov ury or other traumatic event, If a Medical Examinar must be political at 28a-f ehow Yes 2 □ No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 4 Divorced 3 Widowed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Cellege (1-4or 5+) 17. Father's Name (First, Middle, Last) (UNKNWN) 18. Mother's Name (First, Middle, Maiden Surname, Be 2 19b. Mailing Address (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 19a., Informant's Name/Relationship (Type,, Print) Brooks (Grandauphter) 2014 My Complete of Disposition (Name of Complete), crematory of other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 1 Burial 2 ☐ Cremation 3 ☐ R permit. Page Department o Important: If any injury or Kaltimore ZIM Greene Funeral Sinc. 21. Signature Funeral Sej 22. Name and Address of Facility Down, MD 21123 Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DAMS. Physician HAEMATOM RICHT THACAMIC SIDED /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 Ø No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 No 1 Yes 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Ninpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 No 1 Tyes 2 Accident 3 🗌 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MID (DIN RANIPATI) 03 01 2004 AT 2438946 D13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIV. PARKWAY RACTMORE MO - 2/2/8 UNION MEMORIAL HOSPITAL RAVIPATI 32/Registrar's Signature State 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day elle 28,2004 **Physician** RIN 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and name Examiner If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min. Months 1 ☐ M 2 🗷 F 58-Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylannent of Health and Mental Hygiene.

ent: If item 27 is marked other than "natural", or Itema 23s or 28s-1 show ary or other traumatic event, Ita Madical Examine meat be notified at 1 XYes 2 □ No Director Varyland 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 22 2/2/ Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2)X No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OVOT Importent: If iten any injury or othe gace. 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) edar Cemelery 21. Signature of Funeral Service License 22. Name and Address of Facility Joseph L. Rus 2222 W. North Hom Ave. 23a. Part . Enter the disease, or complications that bassed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart jailure. List only one cause on each line. Approximate Interval Between Onset and Death Th MI Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or a consquence of). Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 2 Fetal death Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 □ Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate has 1 Yes 2 No or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 Inpatient Other: Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

31. Date filed

5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A AH MED SZI & Eulaw ST

32. Registrar's Signatu

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		For State Ragistrar	State of Maryland	Cei	tificate of	Death	Re	eg. No.	
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Esme Gladys Pfarr					2. Date of Deat Month Februar	y 26, 2004	3. Time of Death
Examin		4a. Fecility Name (If not institution, give str Stella Maris	reet and number)		Dulaney	-		4c. County of Death Baltimore	е
Funeral Director		213-28-9364	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Feb. 21	Year) 9. Birth Cou 1919 Aust	olace (State or Forentry) ralia
Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore		y Town or Lo					10d. Inside City Lin 1 ☐ Yes 🏖
with the 3a or 28s	i Direc	10e, Street and Number 3944 Perry Hall Bou	levard		10f. Zip Code 21128		1	U.S.A.	ntry?
s 1 and 2 should be filed within 72 hours after death with the Maryland it Health and Mental Hygiene. It Health and Mental Hygiene item 71 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Ite Martical Examinet must be nutilized at	by Funeral Director		2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 250No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cubin	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White Specify: Wh	
permit. Pages 1 and 2 should be filed within 72 hours after dea Department of health and Mental Hygiene. In the 12 fem in the 12 fem and Mental Hygiene. In the 12 fem and injury or other traumatic event, Its Madical Examiner many injury or other traumatic event, Its Madical Examiner many injury.	Completed t	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0·12)	ation	(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Business/In	ndustry
be filed wi tal Hygien d other th	Be	12 17. Father's Name (First, Middle, Last)		Seams	cress		me (First, Middle,		
nd 2 should be fill lih and Mental Hy 27 Is marked oth traumatic eveni	2	Albert Cannon  19a. Informant's Name/Relationship (Typ)				and Number or R		r, City or Town, State, Zi	
s 1 and 2 f Health item 27 l		Anthony Pfarr (Son)  20a. Method of Disposition	20b. P	lace of Dispe	Perry Ha			rry Hall, M 20c.Location-City or T	
permit. Pages 1 ar Department of Hea mportant: If item any injury or othe ance.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify) 21 9 ☐ lature 3 ☐ march 3 ☐ Icenset	omoval from State Oal	k Lawn	Cemetery	Marc		4 Baltimore	
Dermis Depar Import any ir	(	23a. Pan 1 Emer the disease, or complic			1407 old	<u>l Easterr</u>	Avenue,	l Home, P.A Essex, Mar	yland 21
of 00, cate be executed obysician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that infitiated events resulting in death) Last	Due to (or as a conseq						
Hecolds, P.O. BOX 00/00,  The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	Bc. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	death 3	□Ectopic pregnanc □ Other (specify) _	ry .		23d. Date of deliment	very Day Year
ires that the signed by	by	Part II. Other significant conditions conf	tributing to death but not res	ulting in the i	underlying cause gi	ven in Part I.		obacco use contribute to res 2 □ No 3 □ Pro	the cause of death
	Completed							rmed? prior to death?	opsy findings ava ompletion of caus 2 \( \text{No} \)
Of VICEL F Physician: Th r this certificate	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No H.	ospital: 1 🗌 Inpatient 2 🗀	] ER/Outpatie	nt 3 DOA	hor	eath <i>(Check only o</i> l Home 5 🗆 Resid	<i>ne)</i> Ience 6 ⊡Other <i>(Spe</i> c	ify)
VISION Attending ar death. ector: Alte by the fune	Certification:	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At h building, etc. (Special	28b. Time o Injury ome, farm, s	M 15	ork? ]Yes 2□No		now injury occurred Street and Number or Ru vn, State)	ral Route Number
Hospita 14 hours Funeral	edicai Cer	29a. Certifier 1 Cartifying Phys (Check only 2 Medical Examin	sician: To the best of my kno nar: On the basis of examina and manner stated.	owledge, dea ation and/or i	th occurred at the to	ime, date and plac opinion, death occ	ce, and due to the courred at the time, of	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the within 2 To the comple	Med	29b. Signature and title of certifier	)			1372(		29d. Date signed (Month	Day, Year)
10	3		4			-3	1		//

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 06788 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year PEMBERTON MALCHISH ANN **Physician** PATRICIA 15=50 M 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFOND BELAR ER UPPERCHEJAPEAKE MEDICAL CONTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 24, 1944 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Maryland 1 □ M 2 □ F 60 216-42-4373 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or than "natural", or items 23a or 28e-f show the Medical Examinational be pullified at 1 ☐ Yes 2 No Bel Air Harford Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21015 109 Royal Oak Drive by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Tes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 🗓 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 8 years Pages 1 and 2 should be filed nent of Health and Mental Hygi 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Wheatley August J. Geckle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 913 Oakleigh Beach Road, Dundalk, Md. 21222 Mr. Robert Pemberton/husband Health item 27 i 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1 Department of P Importent: If Ite any injury or ot QIICE. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 3/5/2004 Baltimore, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service licenses 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. Approximate Interval Between Onset and Death 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HASCUD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) the attending physicien a ned for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ emberton. Patricia 1 ☐ Yes 2 →No 3 ☐ Probably 4 ☐ Unknown TRACEREBRAL Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate has 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 2 Pl/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Hospitel or A 4 Homicide To the Hospitel within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified MAZLIT 136 2004 1 21809 DWG ushy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 TIJONIUM WD 21093 4.5. PLABHU MO 2336 YOUK NO 31. Date filed (Md 17) Pay, Xear 32. egistrar's Signature State Registrar

# ELSINS A EXANDE Baltimore, Maryland 21215-0036 なせ KNOWN PATIENT

Box 68760 P.O. I Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06789 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Alexander Pelsinski Yeer **Physician** 1:28 AM FEBRUARY 21 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL OF BALTIMORE **Baltimore City** BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Sex 1 M 2 ☐ F **Funeral** 90 202.10.4353 Yrs Director October 6, 1913 Conn Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10c. City, Town or Location 28a-f ehow ed other then "netural", or Iteme 23e or 28a-f ehovevent, the Medical Examiner must be notified at 1 Yes 2 □ No **Baltimore City** Director **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 U.S.A. 1623 West Pratt Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give/ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Copper permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then any injury or other traumatic event, ITEM any office. Elementary/Secondary (0-12) College (1-4or 5+) Welder-Steamfitter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Felix Pelsinski Rosie Staskiel 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4805 Lauren Court Ellicott City, Maryland 21043 Ms. Catherine Pelsinski Daughter-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 02/25/2004 Baltimore, MD **Bayview Crematory** 21. Signature of Funeral Service bicensee 22. Name and Address of Facility Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott (

23a. Part1. Enter the diselve, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** GASTROINTESTINAL BLEED 3 DAYS resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated awarts. Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medicai IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 4 Unknown HYPOXIC RESPIRATORY FAILURE 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 27. Many r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.
To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Michele Henlay, M.D. RESØØØ FEBRUARY 21, 2004

Registrar DHMH 17 Rev 1/2001

n

State

32 Registrar's Signature

MICHELE HENLEY, M.D. SINAI HOSPITAL 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215
31. Date filed (Month, Day, Year) 32 Pagistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 0 4 2004

			1 - For State Registrar	State of Maryland	/ Department of Health and Certificate of Death	Mental Hygien	
)	Physici /Medio Examin	al	Decedent's Name (First, Middle, Las     VONITA     4a. Facility Name (If not institution, give	LUCILLE	ROBINSON 4b. City, Town, or Location of Dea	FEB 2.	ay Year 4 1:55 PM c. County of Death
	Funeral Director		5. Social Security Number 6. Se	E NURSING HOI EX 7. Age (In yrs. la M 2 X F		s. 8. Date of Birth	BALTIHORE  9. Birthplace (State or Foreign Country)  MARYLAND
	the Maryland 28a-f show notified at	rector	10a. State 10b. County  MARYLAND N  10e. Street and Number	10c. City,	Town or Location  BALTIHORE  101. Zip Code		10d. Inside City Limits 1 △ Yes 2 □ No  Citizen of What Country?
ဖွ	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or flame 23e or 28e-f show ent, the Madical Examirer must be motified at	Funeral Director	2423 WEST  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 \( \text{Yes} \) 2 \( \text{M} \) No If Yes, Give	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		14. Race - American Indian, Black, White, etc.
1215-0036	rithin 72 hours ne. han "natural", e Madical Exe	Completed by	3 Widowed 4 □ Divorced  15. Decedent's Ed (Specify only highest grade)  Flementary/Secondary (0-12)	Year or Dates:	16a. Decedent's Usual Occupation (Give kind of work done during most of wife. DO NOT use retired)	orking 16b. I	Specify: BLACK Kind of Business/Industry
Maryland 2121	should be filed with nd Mental Hygiene marked other than umatic event, the than	To Be Cor	17. Father's Name (First, Middle, Last)  WILLIA-M	ItA	DALES FERSO 18. Mother's No.  CKETT MAR	ame (First, Middle, Maide	PARTMENT STORE in Sumame) SMITH
altimore, Mary	es 1 and 2 sho of Health and if item 27 is ma sr other trauma		19a. Informant's Name/Relationship (7  MARCARET RHO  20a. Method of Disposition  1 Burial 2 Cremation 3 Company  4 Donation 5 Other (Specify	DES ( 20b. Pla Removal from State	19b. Mailing Address (Street and Number of F 1257 No BENTALS ce of Disposition (Name of metery, crematory or other place) 33017U.S CEMETERY 03	Date   20c. L	or Town, State, Zip Code)  LTO MA 21216  Location - City or Town, State
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	. Willian	22. Name and Address of acility of FULT	ROWN TR.	FUNERAL HOME ALTO, MD. 21217
<b>)</b>	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to for as a conseque	Do not enter the mode of dying, such as cardio	ac or respiratory/arrest,	Approximate Interval Batween Onset and Death
8760,	te be executed ysician and le burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque  C.  Due to (or as a conseque  d.			
P.O. Box 68	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ② No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown	leath 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
Records, P.	The law requires that the tte has been signed by th bage 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Rec		e Completed	25. Was case referred to medical		26 Pleas of D	24a. Was an autopsy performed? 1 Yes 2 1 No	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
>	/siciu	To B	examiner? 1 ☐ Yes 2 D Ho	Hospital: 1 ☐ Inpatient 2 ☐ El	0.4	Home 5 ☐ Residence	C Other (Specific
ō	된 는 je		27. Manner of eath	28a. Date of Injury 2	8b. Time of 28c. Injury at	28d. Describe how inju	
Division of	or Attending filer death. irector: After n by the funer	Certification:	1 UN ural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		Injury Work?  M 1 ☐ Yes 2 ☐ No  le, farm, street, factory, office		nd Number or Rural Route Number,
	To the Hospitel or Attending Physician: To the Funerel Director: After this certific completely filled in by the funeral director.	edical Ce	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	vsician: To the best of my knowl iner: On the basis of examinatio and manner stated.	edge, death occurred at line time, date and place in and/or investigation, in my opinion, death occ	e, and due to the cause(s curred at the time, date an	s) and manner as stated. Id place, and due to the cause(s)
)	To th withir To th	Me	29b. Signature and title of certifier	CC D	29c. License number 4005 447		ate signed (Month, Day, Year)
	Sta	te	30. Name and address of person who can addre	ompleted cause of death (Item 2	- Dr. Suite III Tou	son, MD	21204
	Rogistr	25		The state of	ABRAGA I		

			FOR	partment of Health and N ertificate of Death		ene 200	4 0679
	Dhariaia		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Glenna Maude Ragan	4b. City, Town, or Location of Death		y 29, 2004	1:30 A M
	Examin	er	4a. Fecility Name (If not institution, give street and number) 3202 James Run Road	Aberdeen		Harford	
	Funeral Director		5. Social Security Number  218-32-7401  6. Sex 1□ M 2☑F  7. Age (In yrs. last birthda 68 yrs.		8. Date of Birth (Month, Day, Y Feb 2,	(eer) Cou	place (State or Foreign ntry) ginia
7	>		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or	Location			10d, Inside City Limits
Apple	ahov a pa	or	MD Harford Aberdee				1 □ Yes 2 ☑ No
4	28e-	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Cou	ntry?
th trian	23a o	al D	3202 James Run Road	21001	Ī	Jnited Sta	
	I', or items	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Sp tf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:</li> </ol>	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White Specify: Whi	etc.
Glad within 70 hours after doorh with the Mandard	Fleath and Mental Hygiene.  The first and Mental Hygiene.  Other traumatic avant, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed)  [G]  Elementary/Secondary (0-12)  College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of work a. DO NOT use retired)	king	Sb. Kind of Business/le Department Defense	ndustry
7	Hygier ther th	e Coi	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma		
= 3	ental ked o lc ava	To Be	Caleb Branscome	Maude	Dalton		
ar yra	and Mental Hygiene.  In marked other than sumatic avant, the M			ailing Address (Street and Number or Ru			p Code)
ב י ט	of Health of Hea			)2 James Run Road,		MD 21001  Oc. Location - City or T	own. State
5	nent of the		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	eake Crematory	Mar 2	Beltsville	
	Department of the Importent: If ite any injury or of once.		21. Signature of Funeral Service Licensee  Mo0986	22. Name and Address of Facility Cremation and Fur 8717 Green Pastur	neral Alte	ernatives	
00,	hysician and physician and the printer transit	Ilcai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Caucer			Interval Between Onset and Death
Ŏ .	e attending pod for use as	Physician/Medical		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delin	very Day Year
ds, r	requires that the been signed by the hould be detache	ρ	Part II. Other significent conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death? bably 4 Unknown
9	2 8 8	Completed			24a. Was an autopsy performe	ed? death?	opsy findings available ompletion of cause of
	rtifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one)		
0	ng Pny fter this ineral c	ပ	1   Yes 2   No	e of 28c. Injury at	ome 5 Residen 28d. Describe how		ify)
DIVISION	To the Hospitian or Attending within 24 hours atten death. To the Funatel Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	n 24 hour Ne Funare	ledical (	29a Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, do not not not not not not not not not no	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the cau irred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	withi To th	ž	29b. Signature and title of certifier	29c. License number	296	d. Date signed (Month	Day, Year)
	18		Cen S VL MS	W7161	7	.Vlanch 1	2004
_	\		30. Name and address of person who completed cause of death (Item 23a) (Ty  4 9  31. Date filed (Month, Day, Year)  32. Registrar's Signature		Ulud	White Ha	oh, MW
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	the set of			

DHMH 17 Rev 1/2001

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		-	For State Registrar	State of Ma	ryland	d / Depa <i>Ce</i>	artmen rtificate	t of H	ealth a	and Me		iene2 (	104	_	
	D1 1.1.		Decedent's Name (First, Middle, Last)								2. Date of Deat		Year a	3. Time of	
	Physicia /Medic		MILTO	<b>N</b>			RASIN				FEBRUAR	7		5:40	Рм
	Examin		4a. Facility Name (If not institution, give st	reet and number)			4b. City,	Town, or	Location of		1 5	4c. Coun	ty of Death	CARROI	1
			FAIRHAVEN 5. Social Security Number 6. Sex	7 Age	(In urs I	ast birthday)	If Under	1 Year	J Y KI	ESVIL			9. Birthr	lace (State	
	Funeral Director			M 2□F	86	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, MAR . 8 , 1	<sup>Year)</sup> 917	Coul	ntry) M[	
	2		Usual Residence of Decedent												
	how		10a. State 10b. County	1	10c. City	, Town or Lo		_						10d. Inside C	2 No
	Ba-f a	cto	MD CARROL	.L		SYKE	SVILL					0. 0'1'	/ What Com		Х
	ith th	Dire	10e. Street and Number				10f. Zip	Code	0170	1.4	,	0g. Citizen o		nu y r	
	s 23e	rai	7200 3RD AVENUE	2. Was Decedent B	ver in U	S 13	Was Dece	tent of Hi	2178		cify Yes or No-	U.S.A	ace - Ameri	can Indian,	<del></del>
က	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiana. item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Medical Examinar must be indiffied at	Funeral Director	11. Marital Status  1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ N If Yes, Give		1	If Yes, spec 1 ☐ Yes		n, Mexican Specify:	, Puerto F	cify Yes or No- lican, etc.)	Spec	lack, White,		
21215-0036	ural', c	d by	3 X Widowed 4 □ Divorced	Year or Dates:										WHITE	
5	natu	Completed	15. Decedent's Educ (Specify only highest grade	ation co <i>mpleted)</i>		(Give	dent's Usua kind of wo DO NOT us	rk done d	luring mos	t of workin		16b. Kind of	Business/in	dustry	
12	withir ena. then	d mc	Elementary/Secondary (0-12)	College (1-4or 5	+) 4	OWN			,			PHARM	1ACY		
	filed Hygi other		17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle, I	Maiden Sumi	ame)		
Maryland	Aental Aental rked c	To Be	HARRY			RASINS				NNIE_				COH	IEN
lan	2 sho and I is ma		19a. Informant's Name/Relationship (Typ			1					Route Number				
	and lealth m 27 har tr		MARC RASINSKY / SC	JN	20h P	80 W			IKEE		ESTMINS	1 EK N 20c. Location			
Baltimore,	iges 1 of of F or of		20a. Method of Disposition 1	emoval from State	a	emetery, cre LTIMOR	matory or o	ther plac					MORE,		
Ę	iit. Pa artmer artant injury		*4 □Donation 5 □Other (Specify)  21. Signature of Fune al Service License	е	DA						LEVINS				
Ba	permit. Pages 'Department of the Important: If its any injury or of Once.		Reportive								ROAD - F				208
			23a. Pert 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused e cause on each lin	the death									Approxima Interval Be	ite itween
Ě	Physician		Immediate Cause (Final disease or condition	Myoch		H 11	NFAR	0/10	M					Huur	
4	/Medical Examiner		resulting in death)	Due to (or as											
	Examiner	-	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequ	uence of):				<del></del>					
	uted I Insit	Examine	Cause (Disease or injury												
Ь	sician and burial-transit	Еха	that initiated events cresulting in death) Last	Due to (or as	a conseq	uence of):									
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68 89	daath cartificate e attanding phys id for use as the	Physician/Med	IF FEMALE:	3c. If yes, outcome	of proces							224	Date of deliv		
Вох	aath cartific attanding p I for use as 1	ian	in the past 12 months?	1 □ Live birth 4 □ Pregnant at	2 Feta	I death 3	⊒Ectopic p ⊒ Other (s						Month	Day	Year
o.	by the datachad	iysic	1 Yes 2 No	9□ Unknown	(1110 0) 0										
٥.	the de	by Ph	Part II. Other significant conditions con	tributing to death b	ut not res	ulting in the	underlying o	cause giv	en in Part I	l.	23e. Did to	bacco use co	ontribute to	the cause of	death?
rds	quiras en sign										1 🗆 Y	es 2 No	3 🗆 Pro	bably 4 🗆	]Unknown
Records,	as seen	Completed									24a. Was a	sy	prior to co	opsy findings impletion of	s available cause of
<u>m</u>		Com									perfor	med? 2 □ No	death? 1 ☐ Yes	2 No	
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:				Oth	05		(Check only or				
of	Phys this at dir	2	1 Yes 2 No	1 Linpatie		ER/Outpatie		JA	4 🗆 NI	-	ne 5 Affesid 28d. Describe h			(fy)	
on	ding h. Aftar fune	tion	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	М	28c. Injur Wor 1 □	k? Yes 2□						
Division	or Attending after death. Director: Aftain by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At he	ome, farm, s	treet, factor	y, office		2	28f. Location (S City or Tow		mber or Rui	al Route Nu	mber,
Ö	tal or A rs after al Direc ed in by	Cert	Tomodo	Dulldling, or	C. (DPCC)										
	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	edicai	29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Exemination one)	sician: To the best ner: On the basis o and manner st	f examina	wledge, dea ation and/or i	th occurred nvestigation	at the tire n, in my o	ne, date ai pinion, de	nd place, a ath occurre	and due to the o ed at the time, o	ause(s) and late and plac	manner as e, and due	stated. to the cause	(s)
	o the ithin 2 o tha omple	Med	29b. Signature and title of certifier	and mainer st			29	c. Licens	e number			29d. Date sig	ned (Month	Day, Year)	,
	ĕ → ₹ →		1 Allona	h.			D	222	20		/	marci	61,	2004	-
•	j		30. Name and address of person who co	mpleted cause of c			, Print)			-					
-	$\varphi$		DR. SARANTE	1645 LI			#204		ELDER	SBUR	G, MD				
	Sta Regist	ate	31. Date filed (Month, Day, Year)  MAD 0 4 20	32. Registr	ar's Signa		A	l Wark	,	7					

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		1 - State Registrar				Cer	tificate of	Death		Reg. No		4 0013
W.	÷e.		me (First, Middle, Last,	)					2. Date of De	aath Da	y Year	3. Time of Death
Physic /Med		ALMETA	STOKES								24 2004	1530 p <sup>M</sup>
Exami			(If not institution, give	street and number)			4b. City, Town,	or Location of Deat	h	4c	. County of Deat	h
			Key Avenue				Baltimo		T =		N/A	
Funeral		5. Social Security		х 7. Ag ] M 2 🗐 F	e (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days		(Month, Da	ay, Year)		hplace (State or Foreign untry)
Director		214 44 Usual Residence	1590	X	62				MAR.7	, 194	Nort	h Carolir
Mo tal		10a. State	10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
분절	tor	MD.	N/A		BAL	TIMO	ORE					1 X Yes 2 No
r 28a	irec	10e. Street and N	<del></del>				10f. Zip Code			10g. Ci	tizen of What Co	untry?
"naturel", or items 23a or 28a-f show edical Esandrier namt be notified at	Funeral Director	5702 K	EY AVENU	E			21215			J	J.S. OF	Α.
Sms .	ner	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or Note to Rican, etc.)	0-	14. Race - Ame Black, White	
or th	y Fu		rried 2 Married	1 ☐ Yes 2 <b>X</b> ☐ If Yes, Give	No		1 □ Yes ၾ No				SpecifyBLA	CV
ural.	d by	3 Widowed	X	Year or Dates:	1 4	10- D	dent's Usual Occu			165 8	(ind of Business/	
nat	lete	(Sp	15. Decedent's Edu ecify only highest grad	le completed)		(Give	kind of work done	e during most of wo				
C 461	Completed	Elementary/Se 11TH	condary (0-12)	College (1-4or:	5+) S	SUPER	RVISOR	OF HOUS	EKEEPEI	RS	HOSPIT	'AL
Mental Hygiene arked other than atic event, the			e (First, Middle, Last)	N/A				18. Mother's Na	me (First, Middle	, Maider	n Sumame)	
Mental rked c	To Be	MOSES	COLLINS	(DECEASE	ED)			JUANIT	A HEWIT	$\Gamma T$	(DECEA	SED)
f Health and Meritem 27 is marke other treumatic	-	19a. Informant's	Name/Relationship (T)	ype, Print)		19b. Mailir	ng Address (Stree	et and Number or Ri	ural Route Numb	er, City	or Town, State, 2	Zip Code)
27 ls		SAMUEL	McDUFFII	E BROTHE	ER IN	LAW	5702 K	EY AVEN	JE BAI	TO.	,MD. 2	1215
item 27 other tr	b	20a. Method of D	•		20h Place	a of Dicno	cition (Name of		Data	20c. L	ocation - City or	Town, State
			2 □ Cremation 3 □ F n 5 □ Other (Specify)		KING	MEM	MORIAL	PARK 2/2	28/04	BAI	TIMORE	, MARYLANI
E 2 2	100		A									
e 0 = 6		21. Signature of	Functal Service Licens	TE T CW	IVNN	22	Name and Add	ress of Facility	EIINED 7	\ T   L	IOME 2	1215 6202
Department Importent: hand injury o		21. Signature of	Fundal Service Licens	IS T. GW	YNN			ress of Facility GWYNN K HETCH'				
Depa Impo any ir		101-	euro T	Murce	m	4.5	517 PAR	K HEIGH	CS AVE	UIF.		1215-6393 Physical Retrieval Between
		23a. Part1. Ente shock, or h	The disease, or compean failure. List only o	lications that cruse ine cause on each I	d the death. [ine.	4.5 Do not ent	517 PAR er the mode of dy	K HEIGH ying, such as cardia	PS AVEN	WE arrest,	BALTO	.?.MD.
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ı	Physicia /Medic		1. Decedent's Name (First, Middle, Last) JOHN J. SLEZAK							Date of Dea Month	Day	Year GH	3. Time of Death 2:45 P M
	Examin Funeral Director		4a. Facility Name (If not institution, give to Somar to 5. Social Security Number 6. Security Number 214-16-8423	n Hospi		ast birthday) Yrs.	4b. City, Town Ball 11  If Under 1 Yea  Months Day	Mare If Under 2	24 Hrs. 8	Date of Birtl (Month, Day	4c. 0	N/A 9. Birt	th thplace (State or Foreign SUNTY VIRGINIA
			Usual Residence of Decedent  10a. State 10b. County			, Town or Lo							
	Maryla f shov	20	MD BALTIM		TOC. City		IMORE						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28e-	Director	10e. Street and Number	ORE		ם אר ז	10f. Zip Code				10g. Citiz	en of What Co	ountry?
	ath wild 23a o	ralD	6814 YOUNGSTOW	N AVE.			212					JSA	
36	within 72 hours after death with the Maryland ane. Than "natural", or Items 23a or 28e-f show to Mouleal Excluder in that the motified a	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: W			Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 ☑ N		in? (Specif , Puerto Ric	y Yes or No- an, etc.)		4. Race - Ame Black, Whit Specify: WH	
215-0036	"natural",	eted	15. Decedent's Edu (Specify only highest grad	cation		16a, Deced	dent's Usual Occ kind of work dor	upation	of working		16b. Kin	d of Business	
2121	2 should be filed within and Mental Hygiene. Is marked other than "eumatic event, Ite Mac	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		life. L	DO NOT use reti ER TOOL	- & DY	E MAI				ELECTRIC
and	d be fil	To Be	17. Father's Name (First, Middle, Last) PAUL SLEZAK						r's Name <i>(F</i> Y OR]	First, Middle,	Maiden S	Sumame)	
Š	s 1 and 2 should if Health and Men Item 27 is marke other treumatic	۲	19a. Informant's Name/Relationship (Ty	pe, Print) LEZAK			ng Address (Stre						
Baltimore,	0 0		20a. Method of Disposition  1 3 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	lemoval from State	CE	metery, cren	sition (Name of natory or other p SARY CE		Date / 4 / 0 4			cation - City or DALK,	
Balt	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licens	Carta	3	M 12	ACZORÓV 201 DUN	DALK.	AVE.	BALT	'T MOT		). 21222
	Charles be executed by physician and physician and physician and step the purial-transit	edical Examiner	23a. Part1. Enter the disease, or comples shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a d.	consequ	lence of):	er the mode of d	ying, such as o	cardiac or re	espiratory and	rest,		Approximate Interval Between Onset and Death
O. Box 68	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal	death 3 [	Ectopic pregnar Other (specify)	псу			23	3d. Date of dea	ivery Day Year
rds, P.O.	quires that the signed by an signed by and be detacted.	ed by Ph	Part II. Other significant conditions con	ntributing to death but		ilting in the ur	nderlying cause	given in Part I.			obacco us		o the cause of death?
Division of Vital Records,	The law recate has being page 2 sho	Completed by								24a. Was a autop perfor 1  Yes	sy	24b. Were au prior to death? 1  Yes	utopsy findings available completion of cause of
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ion of	To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	atlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		ER/Outpatien 28b. Time of Injury	28c. In	4 🗀 1901	280	5 ∐ Resid		Other (Spe	cify)
Divis	tel or Atters after des el Director ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At ho (Specify	me, farm, str	eet, factory, offic	6	28f.	Location (S City or Tow	Street and m, State)	Number or Ru	ural Route Number,
	B Hospi 24 hour B Funer etely fill	edical	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of ner: On the basis of a and manner state	examinat	wledge, death ion and/or in	n occurred at the vestigation, in my	time, date and opinion, deatl	d place, and h occurred	I due to the d at the time, o	ause(s) a date and p	and manner as place, and due	s stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier				29c. Lice	nse number	-	- 2	29d. Date	signed (Mont	h, Day, Year)
	*		Lou M. Wa	gennan	M	0.	RES	00	0		2/2	29/0	14.
	10		30. Name and address of person who co	moleted cause of dea Hospitel	ath (Item 500		Print) h Rave	n Bluc	t. Ba	Himo	ore N	40 2	1239
	Sta Registi		31. Date filed (Month Day, Year) MAR 0 4 2004	3 Registrar		ture					1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	

State of Maryland / Department of Health and Mental Hygiene 2004 06796 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 1. 2004 Physician Robert J. Sabatini 2:15 P M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner 4508 Cedell Place Camp Springs Prince George's If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/28/1934 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1⊠**X**/ 2□ F 69 Yrs. Director 189-26-7480 Pennsylvania Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ir Itams 23a or 28e-f ehow inter must be notified at Maryland Prince George's Camp Springs 1 ☐ Yes 🏋 🗓 No Directo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4508 Cedell Place 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed withn 72 hours after 1 X Xes 2 □ No 1957-1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò White 1 ☐ Yes 2KTXNo Specify: the Hadical Expr Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 1963 "netural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auditor Federal Government other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be 27 is marked of traumatic ever Boni Sabatini Elizabeth Cecelia Gregor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is eny injury or other training once. Frances Payne Sabatini/Wife 4508 Cedell Place Camp Springs, MD. 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tXXBurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cem. 3/6/04 \* 4 ☐ Donation Ø ☐ Other (Specify) Clinton, Maryland 22. Name and Address of Facility P. Kalas Funeral Home P.A. 21. Signature of uneral Service Licenses also 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part1. Enter the disease, or comshock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit law requires that the death certificate be executed Exami Due to (or as a consequence of) Box 68760, Physiclan/Medical the έ as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ page 2 should Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? certificate 1 Yes 2 X Clo 25. Was case referred to medical funeral director 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXVo Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t XX Matural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 Tes 2 🗌 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29b. Signature and tifle of dertifier 29c. License number 29d. Date signed (Month, Day, Year) 0101225490 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert J. Christie, M.D. 1635 N. George Mason Dr. #170 Arlington, VA. 22205 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 06797 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month Physician Smith 27 12:15p Lee 2004 Ida /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Towson Manor Care N.H. Birthplace (State or Foreign Country)
 N . C . If Under 1 Year | 1f Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 10-12-31 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2**K**) F 241-42-1412 72 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Evanuar mast be notified at 1 Yes 2 No NΑ Baltimore Md. Directo 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code With USA 21239 1338 Pentwood Rd. death v Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: if item 27 is marked other than "natural; or item ury or other traumatic event, it as Medical Exaculation or other traumatic event, it as Medical Exaculation. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Nursing Assit Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Smith Mozell Leroy 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau Bernadette Harris Daughter 1338 Pentwood Road, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3-3-04 King Mem. Pk. Randallstown, Md. 22. Name and Address of Facility Baltimore, Md. 21202 21. Signature of Funeral Service Licensee March F.H. East 1101 E. North Ave. Would 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MUSEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mijury that initiated events) Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certilicate be executed use as the burial-transit signed by the attending physician and be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetai dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 Yes 2 - No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injun 1 Natural 5 Pending investigation after death.

Director: Aft in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a To the Funerel L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mins 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Councit HEPNER MO TEN 31. Date filed (Month, Day, Year) Registrar's Signature MAR 0 4 2004

Registrar

State of Maryland / Department of Health and Mental Hygiene 200 L 06798 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day TACOMA MAE SIDES Physician Felory 23,200 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number, Examiner Professional Year If Under 24 Hrs. Min. 8. Date of Birth (Month Day 3 (ear) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🖫 F W.V. 213 32 3087 66 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 28a-f show other treumatic event, the Medical Examinar must be notified at Yes 2□No MD. BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 501 E.PRESTON ST. (APT. 21202 528) USA "natural", or Itams 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes X☐ No Specify: Specify: BLACK δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of NAPPER ROBERT JULIA M. NAPPER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a 842 W.PARK AVE.BALTO.MD.21201 (APT 104) CECILIA BANKS DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) injury or Department of Important: If any injury or METRO CREMATORY 3/1/04 CATONSVILLE, permit. 21. Signature of Funeral Service Licenses ESTEP BROS. FUNERAL HOME P 1300 EUTAW PL. BALTO. MD. C.A.ESTEP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending ph I for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 1 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy performed? 2 No 2□ No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 24 hours after death.

• Funeral Director: A 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1h Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 0 4

**ORIGINAL** 

Registrar

Baltimore, Maryland 21215-003

Jama

04-01516 John Sulak RJD

Baltimore, Maryland 21215-0036

68760

Box

P.O. I

Records,

Division of Vital

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2001 For State Unpend Item#23a, Part II, 27, Per ME, C829 3/110/Over Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Febuary 29, 2004 **Physician** 0230A. IOHN SIII AK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 12404 Kembridge Drive Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1 XXXM 2 □ F 40 Director 160-62-2094 PHILADELPHIA, PA MARCH 12, 1963 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show The Medical Examiner must be notified at 1 Yes 2 No Directo MARYLAND PRINCE GEORGES BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12404 KEMBRIDGE DRIVE Items 23e 20715 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 Never Married 21X Married 0 1 Yes XX No Specify: à Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced ear or Dates 'netural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DIRECTOR OF COMMUNICATION 12 HOSPITAL marked other other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be tand Mental I ဥ JOHN J. SULAK, SR. KATHLEEN HEISLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYLVIA J. MILLER-SULAK - WIFE s 1 and 2 of Health 12404 KEMBRIDGE DRIVE, BOWIE, MARYLAND 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Peges 1
Department of He
Important: If Iter
any injury or oth 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Ø Cremation 3 ( ☐ Removal from State LIBERTY GREMATORY \* 4 ☐ Donation 5 ☐ Other (Specify) MARCH 4, 2004 PHILADELPHIA, PA 21. Signature of Funeral Service 22. Name and Address of Facility FINK FUNERAL HOME, PA/MARYLAND MORTUARY Moon 426 CRAIN HIGHWAY S, GLEN BURNIE, MARYLAND 21061 KELLY PRECO FINK #M01148 nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Par 1. Enter the disea shick, or heart failure Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Hypertensive Atherosclerotic Cardiovascular Disease Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and burial-t Due to (or as a consequence of): attending physicien Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy lor in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Cirrhosis of the Liver 2 No 1 ☐ Yes 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 QOther (Specify) (SCEDE) 2 Yes 2 No 2 ER/Outpatient 3 DOA completely tilled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Atter 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director; 3 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) atter 4 Homicide To the Hospitel 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated within 2 To the 29d. Date signed (Month, Day, Year) Febuary 29, 2004 29b. Sigrature and title of certifier 29c. License number O.C.M.E. Kel W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 MARYSROAS KOREI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 4 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Amend Item 22 p	er FH, G829, 03/04/	od / Departme 04dhb <i>Certifica</i>	ent of Health and atte of Death	Mental Hygie		06800
	Physici		Decedent's Name (First, Middle, Last	reats			2. Date of Death Month	Day Year	3. Time of Death
9	/Medic Examir		4a. Fecility Name (H-hot institution, give		4b. Ci	y, Town, or Location of Dea	1	4c. County of Seeth	1,000
	Funeral		5. Social Security Number 6. S		last birthday) If Und Month	ler 1 Year If Under 24 Hr s Days Hours Mir		9. Birthol Count	ece (State or Foreign
h	Director		Usual Residence of Decedent	□M 22 (F   82	Yrs.	S Days 710dis 1911	quonth Day, Y	South	"_NO
	Maryland	tor	10a. State 10b. County	10c. Ci	ty, Town or Location	hllstown		10	0d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Itam 27 le markad other than "natural; or Itama 23a or 28a-f ehow importent; If Itam 27 le markad other than "natural; or Itama 20 en called an once.	Funeral Director	10e. Street and Number	W PD	10f. 2	Zip Code 01/22	10g.	Citizen of What Count	try?
	tama 23	unera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was Dec	edent of Hispanic Origin? ( becify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - America Black, White, e	
036	ral', or I	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 DaNo If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: B	ACK
21215-0036	nin 72 hi In "natu Mocell	Completed	15. Decedent's Ec (Specify only highest gra Elemantary/Secondary 40-12)		16a. Decedent's U: (Give kind of the life. DO NOT	vork done during most of w	orking 16t	b. Kind of Business/Ind	lustry
	iled with Hygiene ther tha nt, the		17. Father's Name (First, Middle, Last)	NJH	Co	UK 18 Mother's Na	me (First, Middle, Mai	+ MEQ	de
Maryland	should be to and Mental to marked o	To Be	George Little	e		Lill	ie Brou	U)	
_	and 2 sh Balth and n 27 le m		19a. Informan ame/Relationship (1	tert (Niecze)	19b. Mailing Addre	ss (Street and Number or F	ural Route Jumber, Ci	ity or Town, State, Zip	Code) D 2121)7
nore,	Pages 1 and of He out: If Itam		20a Method of Disposition  1 Burial 2 Cremation 3	Removal from State	Place of Disposition (A			. Location - City or Tov	wn, State
Baltimore,	permit. Pa Departme Importent any injury		21. Signature of Funeral Service Licen	2	8728 ame	and Address of Facility	aughn Co	Sverin Fu	neral Sic.
	# # # # #		23a. Part1. Enter the disease, or companion, or heart failure. List only	plications that caused the dear	8/02	: Liberty KD	Kamale ac or respiratory arrest,	town, mc	Approximate Interval Between
ì	Physician		snock, or near tailure. List only a Immediate Cause (Final disease or condition resulting in death)	a and si	tage Clir	on toloto	upre lu	no Dicen	Onset and Death
	/Medical Examiner			Due to (or as a consec	nead of):	Fibrus	3	0	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):	in			
8760,	The law requires that the death certiticate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	al Exa	resulting in death) Last	Due to (or as a consec	quence of):	ascula	Distas	20	
မှ	rtiticate be e: ng physicien s as the buria	Medical	IF FEMALE:	d	rax v	TWILL WITH	121 7 672		
Вох	death certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregni 1 Live birth 2 Fete 4 Pregnant at time of c	el death 3 Ectopic			23d. Date of deliver Month	Day Year
<u>о</u> .	that the de led by the a detached t	Phys	9 Unknown  Part II. Other significant conditions of	9☐ Unknown	sulting in the underlying	cause given in Part I	23e Did tobacc	co use contribute to the	a causa of death?
Records,	w requires that been signed should be del	ted by	Diabe	tio		, outside given in reaction	1 ☐ Yes		
Reco	The law resate has be page 2 shi	Completed					24a. Was an autopsy performed	prior to com	sy findings available apletion of cause of
/ital	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	N			1 ☐ Yes 2. Z ath (Check only one)	No 1 ☐ Yes 2	2 No
Division of Vital	Phys this al di	n: To	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 ☐ t 28b. Time of Injury	OOA Other: 4 Nursing 28c. Injury at Work?	Home 5 Residence	e 6 □Other (Specify) injury occurred	Hospi 6
isior	Attending or death.  ector: Alter by the funer	Certification:	2 Accident 5 Pending 2 Natural 5 Pending investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐ No	28f Location (Street	t and Number or Rural	Route Number
<u>&gt;</u>	itel or A		4 Homicide determined	building, etc. (Special	fy)		City or Town, S	itate)	
	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Ph (Check only one) Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as sta and place, and due to	ited. the cause(s)
<b>b</b>	To the within	W	29b. Signature and title of certifier	2 out	$WO$ $^2$	9c. License number	29d.	Date signed (Month, D	Day, Year)
	N		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	0100-		R- 1-27	20 md
	Sta	-	31. Date filed (Month, Day, Year)	22. Registrar's Signa	USUS ature	UY XOAN	w T.	ixupmi	2/224
	Registr	ar	MAD A A 2004	No. As	A . 10 a				

State of Maryland / Department of Health and Mental Hygieney 004 06801 For State Registrar Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 28,2004 H: 069M MARY /Medical County of Death 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WARE If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday, **Funeral** Days Months Hours 1 M M 2□ F 781 77-30 Director Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
int: If Item 27 is marked other than "natural", or Itame 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic avent, the Mudical Examiner must be notified at 1 Yes 2 □ No Director Mary and more 10f. Zip Code 10g. Citizen of What Country? 21 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) borer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19a. Informant's Name/Relationship (Type, Print) (son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of P Importent: If its any injury or of once. 1 ☐ Burial 2 🕱 Cremation 3 ☐ F
4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Green Mount Cremater 21. Sig turn of Funeral Service Licensee 22. Name and Address of Excility eral Home Joseph L. Kuss ti 23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SCOSIS /Medical Due to (or as a consequence of): Examiner umag 1000 00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No 20 Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 🗆 No certificate 2 No 1 Yes 1 ☐ Yes To the Hospitel or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: Other: 70 1 🗌 Yes 1 Inpatient ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this o 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending death. M 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Direc 4 THomicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified Echruary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 MD Date filed (Month Day Year) Registrar's Signature 2004 State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 06802 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death DOROTH Month **Physician** THOMAS 5,3TPM 10 RL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOURS HOSPITAL BALTIMORE N/A5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 213-20-8068 1 ☐ M 2 🕅 F JULY 9, 1916 **Director** 87 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-1 show in then "natural", or items 23a or 28e-f show the Modical Examinational be notified at MXYes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2407 BAKER STREET 21216 **IISA** by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify Specify: 3√√Widowed 4 □ Divorced **BLACK** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: if item 27 is marked other the any linury or other traumetic event, the gones. CORRECTIONAL OFFICER LAW ENFORCEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES SIMPSON ISABELLE PIPIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL PARRAN/DAUGHTER 2407 BAKER STREET BALTIMORE, MARYLAND 21216 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) KING MEMORIAL PARK 3-6-2004 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 12 Spor /Medical Due to (or as a consequence of): Examiner Re Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician and ched for use as the burial-transit certificate be executed ND Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 ☐ Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 Unknown mentel 1 ☐ Yes 2 ☑ No peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? Sep S18 1 ☐ Yes 2 ☐ No of Vital 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 XÑo 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Momicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3/11 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hokpeh 91 Balt, mo 21215 2600 HEITS Ave mo 32. Registrar's Signature 31. Date filed (Mor State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 06803 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** F. Thomason Eula 2004 February /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner None HOPKINS Baltimore If Under 1 Year | If Under 24 Hrs. HOSpita TOHNS 1 Ty 8. Date of Birth (Month, Day, Year) 3/8/1913 9. Birthplace (State or Foreign Country) North Carolina Age (In yrs. last birthday) 5. Social Security Number Funeral Days Hours 90 217-44-2396 1 ☐ M 2 ☐ XF Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location or 28a-f show other treumatic avant, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Maryland Saint Mary's Director California 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23250 Chestnut Oak Court Apt.1032 20619 USA or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 

Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary U.S. Dept. of Agricul-12th permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 Is marked other i sny injury or other treumatic svent, II. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rufus Lewis Feimster Kiter Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark A. Thompson/Grandson 25385 Allston Lane Hollywood, MD. 20636 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 3/5/2004 Suitland, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur Funeral Service Licensee 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a Ann. Enter the dispesse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) flau to blood Lack 10 seconds **Physician** organs /Medical Due to (or as a consequence of): **Examiner** ulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine transit veno-s thrombosts 200 and physicien as the burial-t Box 68760, Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 MNo Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, accident 1 Yes 2 No 3 Probably 4 Unknown a resisvascular Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy performed? 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After t 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel E Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifie lerson Ph.O. M.D. RES-000 February 29, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Hopkins Haspital, 600 North Wolfe Street William Stunley Anderson 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrer	State of Marylar	nd / Departm Certific	ent of Health a	and Mer	ntal Hygien	e 2004	06804
	Physici /Medic Examir Funeral Director	al	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (II not institution, give some second security Number second security Number second security Number second security Number second second security Number second security Number second seco	Street and frumber)  7. Age (In yrs.	- Ho	A PSON City, Town, or Location of Set Sound of 1 Year If Under this Days Hours	of Death	Date of Death Month Da  OVCH 0.2  4c  Date of Birth Month Day, Year, ULY 17,	2004 County of Death	3. Time of Death 0556 A M  Description  Observed the State of Foreign  Observed the State of
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Ie marked other then "naturel", or Iteme 23a or 28a-1 ehow an important: If item 27 Ie marked other then "hatter in the marked programment of the marked prog	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Washingt  10e. Street and Number  55 E. Washington  11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  (Specify only highest grade  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  Joe Donald Searige	10c. Ci Has  Street #609  12. Was Decedent Ever in U Armed Forces? 1   Yes 2 MNo If Yes, Give Year or Dates:  cation cation College (1-4or 5+) 3	ty, Town or Location  gerstown  10f.  2 J.S. 13. Was Do If Yes,  1 □ Ye  16a. Decedent's I Give kind of life. DO NO  Homemake	( work done during mos T use retired)  18. Mothe	igin? (Specify n, Puerto Rica : st of working er's Name (Fil	Yes or No- In, etc.)  16b. K  Own rst, Middle, Maider	A  14. Race - Amenia Black, White, Specify: Kind of Business/In  Home In Sumame)	SáS  10d. Inside City Limits  1  Yes 2  No  Intry?  can Indian, etc.  White
Baltimore, Mar	permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Ie m eny injury or other traum once.		19a. Informant's Name/Relationship (Ty, Frank H. Thompson, 20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)  21. Signature of the eral Service License FOWARD A. CA	Jr./Husband Jr./Husband Jemoval from State Met	55 E. Wa Place of Disposition ( cometery, crematory tro Cremat	Name of	treet Date 3-3-04	#609 <u>Ha.</u> 20c. L Bal	cerstown, ocation - City or To ltimore,	MD 21740 own, Stete
x 68760,	Physician fundamental fundamen	/Medical Examiner	23a. Part1. Enter the disease, or demplishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a))).	th. Do not enter the natural subsection of t	mode of dying, such as	cardiac or res	spiratory arrest,	, detail	Approximate Interval Between Onset and Death
Records, P.O. Box	The law requires that the death certifica tie has been signed by the attending phoage 2 should be detached for use as the	Completed by Physician/M	23b. Was decedent pregnant in the past \$2 months?  1  Yes 2 No 9  Unknown  Part II. Other significant conditions con	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 Ectopi death 5 Other		[		use contribute to th	Day Year
Division of Vital Re	tending Physician: leath. tor: After this certifica the funeral director, p	Certification: To Be Comp	27. Manner of eath  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Ospital: 1 Inpatient 2 28a. Place of Injury (Month, Day Year)	28b. Time of Injury M	DOA Other: 4 Nu 28c. Injury at Work? 1 Yes 2 1	o of Death (Charsing Home 28d.	autopsy performed?  1 Yes 22 No eck only one)  5 Residence Describe how injure	prior to cordeath? 1 Yes 6 Other (Specify	mpletion of cause of  2 No  y)
Div	To the Hospitel or within 24 hours afte To the Funerel Dirac completely filled in the Total comp	Medical Certif	4 Homicide determined  29a. Certifier (Check only one)  29b. Signature and title of certifier	building, etc. (Specificien: To the best of my knoter: On the basis of examina and manner stated.	owledge, death occurr Ition and/or investigat	red at the time, date and	d place, and d	Gity or Town, State due to the cause(s) the time, date and	and manner as st	lated. the cause(s)
	Sta Registr		30. Name and address of person who co	mpleted cause of death (Iten	edicol Coly	gie R1.5	re Isc	Hosos	Bur, A	Z 2716 CM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06805 State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 12:05 AM 2004 rayson /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SAINT AGNES HEALTHCARE BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Min. 10 M 2□ F Months Davs Hours 3-14-956 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Evantuer must be notified at 1 Yes 2 □ No Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' or Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced Slac "naturel" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Menial Hygiene. Important: If Item 27 is marked other than "ne eny injury or other traumatic avent, the Mudic once. Elementary/Secondary (0-12) College (1-4or 5+) inee 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) (Son) 19a. Informant's Mame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) amsSr TOWN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removat from State ' 4 ☐ Donation 5 ☐ Other (Specify) al 21. Signature of Funeral Service/Licenses 22 Name and Address of Facility Joseph L. K 2222 W. North Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY days /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) MEARI CONGESTIVE physicien and Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical is certificate has been signed by the attending physi director, page 2 should be detached for use as the I IF FEMALE: . If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24e. Was an After this certificate has autopsy performed 2 No 1 ☐ Yes 2 No I or Attending Physicien: after death. Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Longo Kin rollionia 15628 MARCH OR 2004

State Registrar 31. Dete filed (Month, Day, Year)

32. Registrar's Signature

MAR 0 4 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

LARYSA D. KIMMIRIEMICZ, 900 CATON AVENUE, BALTIMORE

SILIAM

		1	- For State RegistAMEND ITEM #1 PER	State of Marylai PHY G829 3/04/	nd / Depa <sub>04 ЛН</sub> Сег	ırtmer <i>tifica</i> ı	nt of Health te of Death	and Me	ntal Hy	giene Reg. No		06	806
	Physicia /Medic	an	<ol> <li>Decedent's Name (First, Middle, Last)</li> </ol>		IE WEBB	<del>L</del> = 1	RIE	4	. Date of De Month とらごし	Da	27 Year 27 200	11	of Death
7	Examin  Funeral  Director	er	5. Sociel Security Number 6. Sex	PITAL	. last birthday) Yrs.	BA	Town, or Location	of Death ORE 24 Hrs. 8	. Date of Bi (Month, D	J4c	9. Birth	nplace (State untry) AL	or Foreign
	o		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity. Town or Lo	cation						10d. Inside	City Limits
	Maryla 4 sho	ŗo	NY Queens	Lo	ng Isl	land	City					1 ☐ Y€	s 2½ No
	or 28e	irec	10e. Street and Number			10f. Zi	p Code			10g. Ci	itizen of What Co	untry?	
	ath wil	ralD	35-35 21st Stre				11106	0 / 0	( N		U.S.A.	ieee Indian	
36	be ilied within 72 hours after death with the Maryland Hygiene.  d other than "naturel", or items 23a or 28e-f show event, the Madical Evaninar must be inclified.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  35□5€Vidowed 4 □ Divorced	<ol> <li>Was Decedent Ever in I Armed Forces?</li> <li>1 ☐ Yes ② No If Yes, Give Year or Dates:</li> </ol>		was Dece fYes, spe I∐Yes	edent of Hispanic Or ecify Cuban, Mexica 2 XNo Specify		can, etc.)	0-	Black, White		
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/au	s 1 and 2 should I Health and Mer Item 27 is marke other treumatic		19a. Informant's Name/Relationship (Typ				s (Street and Numb						10455
	s 1 and if Health item 27 other tr		Diane Studwood-N 20a. Method of Disposition	20b.	Place of Dispo	COLUMN TO SERVICE STATE OF THE PARTY OF THE		Dat			ocation - City or		
ÕE.	6 O		XBurial 2 ☐ Cremation 3 ☐ Re	moval mom State			metery	3/5/0	4	Fa	armingo	lale,	NY
Baltimore,	permit. Page Dependent Important: if any injury o		21. Signature of Funeral Service Licenses		22 M a	Name a	nd Address of Facil	st					
			23a. Part I. Enter the visease, or complice shock, or heart failure. List only one immediate Cause (Final		ath. Do not ent	er the mo		s cardiac or r	respiratory	arrest,	re Ma	2121 Approxim Interval B Onset an	ate ietween
p.l.	Pnysician /Medical		disease or condition resulting in death)	INTRAC  Due to (or as a conse	equence of):	RAL	HEW	ORR	nag	e		40	ays
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58760,	icate be executed physician and s the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse									
•	ntificati ng phy s as the	Medical	IF FEMALE:								ŀ		
O. Box	The law requires that the death certifi ate has been signed by the attending age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown	8c. If yes, outcome of preging 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3□	Ectopic ; Other (s	pregnancy specify)				23d. Date of deli Month	very Day	Year
rds, P.O.	quires that I n signed by uld be deta	þ	Part II. Other significent conditions conf	tributing to death but not re	sulting in the u	nderlying	cause given in Part	l.			use contribute to	the cause of the c	
of Vital Records,	The law requinate has been sipage 2 should	Completed							24a. Wa auto pen 1 Yes	opsy ormed?	death?	completion of	s available cause of
/ital		Bec	25. Was case referred to medical examiner?	2.1				e of Death	Check onl	one			
	ng Phys fter this ineral di	2	1 Yes 2 No His	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury		OA Other: 4 N 28c. Injury at Work? 1 Yes 2	28			6 □Other (Specury occurred	cify)	
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)			-	f. Location City or To		nd Number or Ru te)	ral Route No	ımber,
1	To the Hospitel of within 24 hours af To the Funeral D completely filled in	edical C		icien: To the best of my ki er: On the basis of examinand manner stated.									∍(s)
	To the within To the comple	Me	29b. Signature and title of certifier	A	1 0	1 -	oc. License number			-	ate signed (Month		
	4		) (Duf-		1.D.		RES OO			ret	Bruary	Lt, d	.004
	3		30. Name and address of person who con	All No.	em 23a) (Type,	Print)	HARBOR P	ROS					
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State of Maryland / Department of Health and Mental Hygien 00 L 06807 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2004 **Physician** Mercedes Wheeler Carion 8:15 AM March 1. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) NOV 11, 1919 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 X F Hours 84 Puerto Rico 580-78-5476 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b Counts 10a. State 27 is marked other than "natural", or items 23a or 28a-f show traumatic avant, the Medical Examinar must be maiting at 1 Yes 2 No Harford Bel Air Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 21014 USA 30 E. Broadway #B Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White δ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housekeeping UK. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be and Mental UNK. UNK. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mark Carroll/Guardian 145 N. Hickory Avenue Bel Air, MD item 27 i Health Itimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permif. Pages 1 Department of H Importent: if ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 3-4-04 Baltimore, MD ⁴ 4 □ Donation 21. Signature of Fameral Service Cremation Society of MD, Inc. Š 299 Frederick Road Gregorchik Baltimore, MD 21228 Edward A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition HYPOTHER -2 das **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner PNEUMON Soquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Detail death 1 Live birth in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) O 9 Unknown 9 Unknown signed by 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Vital Records. 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan has 1 ☐ Yes 2 ☐ No this certificate 1∏ Yes Attending Physician: 25. Was case referred predical examiner? Be 26. Place of Death (Check only one) 1 Inpatient 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA ŏ 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funerel Diractor: A death. investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) À 4 Homicide per ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) Soop CHURCHVILLE 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Funeral** Birthplace (State or Foreign 1 □ M 2 🕱 F Director 213-82-7193 44 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-1 show Item 27 is marked other than "natural", or Items 23a or 28a-1 shov other traumatic event, the Madical Exeminer must be notified at Director Maryland N/A Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 Linworth Ave Apt # 1B 21239 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced Specify. Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salon Owner Cosmetologist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 ment of Health and Mental I ant: If Item 27 is marked o John Fenwick Shirley Fenwick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sheriea Waters Daughter 1200 Linworth Ave Apt # 1B Baltimore, Maryland 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H 0 1 Deurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 03/02/04 Baltimore, Maryland Woodlawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed and burial-1 Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 ponths? 3 Ectopic pregnancy ō Day 4 Pregnant at time of death 5 Other (specify) P.O. I detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by pe 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24a. Was an autopsy performs Were autopsy findings available prior to completion of cause of death? page certificate 2**XD**No Division of Vital 1 ☐ Yes 1 TYes or Attending Physician: 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) 1 Yes 2 Do Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA this 28a. Da e of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: After 1 Natural 2 Accident 5 Pending investigation death. 1 🗀 Yes 2 🗌 No within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 T Suicide in by 1 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Hospital 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the and manner stated 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 30. Name K.A. KOVZIC 31. Date filed (Month, Day, Year) 32. Registrat State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 06809 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 6:45P Gaynelle P. Watts February25, 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Glen Burnie North Arundel Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 70 Yrs. Georgia Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show other traumatic event, the Madical Exeminer must be notified at 1X Yes 2 □ No Baltimore MD Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21213 or Itams 23a 2620 E. Oliver Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black Completed by 3 Widowed 4 ☐ Divorced Year or Dates: "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) 12 College (1-4or 5+) nould be filed withing Mental Hygiene. University Hosp. Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ceborn Browner Sena E. Browner ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) • permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra 3 Brook Run Court Germantown MD 20876 Donald Browner Sr.(son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition X□ Burial 2 □ Cremation 3 □ Removal from State Holy Redeemer Cemi3-3-2004 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Estep Brothers Funeral Service P. 1300 Eutaw PL. Baltimore MD 21217 E.N.Walker Jr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Demen ta Physician resulting in death) /Medical Due to (or as a consequence of) **Examiner** beton lalver altrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner Deep ween thurston as the burial-transit The law requires that the death certificate be executed gu and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þe 1 ☐ Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2J⊋No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To this after death.

I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No м 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide pe Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 2 40519 2-27-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Madison Rome, Olan Burnic, 21061, Maryland. MIRZA M. NUSAIREV 1401 2. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 4 2004 Registrar

TSIGAMEIL

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			State Ragistrar  1. Decedent's Name (First, Middle, Las			Cer	uncau	e or L	Jeani		2. Date of De	Reg. No	).		3. Time of De	
	Physicia	an	John Baker White								Februa:	ry Ž	Ž, 20	04	17:00	М
	/Medic Examin		4a. Facility Name (If not institution, give 10242 Little Rock	street and number) Lane				Town, or eder	Location o	of Death		40	County of Fred		ck	
	Funeral Director		217-40-3823		62	birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Bir (Month, Da Nov. 2	th y, Year) 19	9. 41 V	Count	ace (State or Firy) ington,	
	show		Usual Residence of Decedent  10a. State 10b. County  Marrial and Errodomic		c City, To		cation			-				10	od. Inside City I	
	the N	rect	Maryland Frederic  10e. Street and Number	K F	rede	LICK	10f. Zip	Code				10g. Ci	tizen of Wha	it Count	try?	
	h with 23a or st be	ai Di	10242 Little Rock	Lane			2170	02				USA				
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show amy injury or other traumatic event, I'm Macucal Examinal must be notified a once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	r in U.S.		Was Deced f Yes, spec 1 ☐ Yes			gin? (Spe n, Puerto	cify Yes or No Rican, etc.)	D-	14. Race - Black, ' Specify:		etc.	
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2	Hygier Hygier ther th	Co	17. Father's Name (First, Middle, Last)	T	50	ell	·		18. Mothe	er's Name	(First, Middle			aı	Ефитрые	:116
au	ld be lental ked o	To Be	Robert White, Sr.								Ronnho					
ary	and Mand Ms mar		19a. Informant's Name/Relationship (7	Type, Print)							I Route Numb			te, Zip	Code)	
	and 2 ealth m 27 I		Marilyn L. White,								, Frede		k, MD		702	
Jore	ges 1 nt of H if ite or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State			sition (Name to the contract of the contract o								Marylar	nd
Baltimore,	artmer artmer ortent injury		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licentary</li> </ul>		SILLU							_			eral Ho	
Ba	Depa Impo any ii		1 Comback	010	M009	99 1	106 Ea	ast	Churc	h St	reet, I	Fred				
	Pnysician		23a. Part (Enter the disease, or com shock or heart failure. List only Immediate Cause (Final								r respiratory a	arrest,			Approximate Interval Betwee Onset and Dea	en ath
	/Medical Examiner		disease or condition resulting in death)	a. /utrow Due to (or as a co	onsequen	ce of):	1 July	- VI	VIS	. [						
	ted a	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a c	onsequan	es of):										
760,	ate be executed hysicien and the burial-transit	cai Exa	resulting in death) Last	Due to (or as a co	onsequen	ce of):										
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٥	es pe	by	Part If. Other significant conditions of	ontributing to death but r	not resultin	ng in the u	inderlying o	cause give	en in Part I						e cause of dea ably 4 □Unk	
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Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 N Yes 2 □ No	Hospital: 1  Inpatient	م الح	/Outpation	at 20 00	Oth	Ar.		(Check only		e <b>VV</b> )th or	/Cnach	CCENE	
ō		F	27. Manner of Death	28a. Date of Injury	28	Bb. Time o		28c. Injun Wor			me 5 Res 28d. Describe			(Specii)	/ SCENE	
Division	deal deal ctor: y the	Certification:	1 Natural 5 Pending 2 Accident investigation 3X Suicide 6 Could not b 4 Homicide determined	I have sold on the cond of	At home		reet, factor	1 ☐ y, office	Yes 2 🗓		City or To	wn, Stat	te)		I Route Numbe	
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	To the h within 24 To the F complete	Med	29b. Signature and title of certifier	and manner stated					e number				ate signed (			
)	řšř8		> Zakin	19/2 At	3-				O.C.M	I.E.			ruary			
	17		30. Name and address of person who ZABIULLAH	AU		111		Str	eet,	Balt	imore,	Mar	yland	212	201	
2	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's	_		1	n=4								

			1 - State of Maryland	d / Depa <i>Cer</i>	rtment of Health and tificate of Death		ne2004	06811
F		-K	Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
	Physici /Medio		Nicholas Avery Warner			February	y 29, 2004	13:18 M
0.0	Examir	er	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital		4b. City, Town, or Location of Dea Baltimore		4c. County of Death	
9	Funeral Director		5. Social Security Number 214-43-5492 6. Sex 1 ★ 2 ☐ F 9	ast birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		ear) Cour	elace (State or Foreign htry) Cyland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City	, Town or Loc	cation		1	0d. Inside City Limits
	Maryl	tor	Maryland Baltimore Hal	ethorp	е			1 ☐ Yes 2 No
	or 28s	Oirec	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cour	itry?
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-f ahow any injury or other treumatic event, I'm Madical Examinat must be nutified at once.	by Funeral Director	11. Marital Status  1 XNever Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 Yes 2 XNo If Yes, Give Year or Dates:		Vas Decedent of Hispanic Origin? ( Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	Black, White,  Specify: Whi	etc.
21215-0036	in 72 ho n *natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give ) life. L	ent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking 16	b. Kind of Business/Inc	lustry
212	d with giene. er ther	Som	Elementary/Secondary (0-12) College (1-4or 5+)	N/A_		1	N/A	
Maryland	be file stal Hy od oth	Be	17. Father's Name (First, Middle, Last) Kevin Warner, Sr.			me (First, Middle, Ma		
ryla	should ad Mer marke matic	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	Address (Street and Number or F	a Papageor		Code)
	alth ar 27 is		Gloria Schwartz, mother		7 Bell Ave. Hal			0000)
Baltimore,	Pages 1 a nent of He int: If item iry or othe		1X Burial 2 Cremation 3 Removal from State	emetery, crem dowridg	oc morrar	h 5, 2004	Elkridge	
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee	<sup>22</sup> A	Name and Adriss of Facility mbrose Funeral H 719 Hammonds Fer	ome of Lan	sdowne	. 21227
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Į	4. <sup>3</sup> 28	Jer	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	iarina ofly:				
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8760	cate be executed physician and the burial-transit	dical E	Due to (or as a consequ	ence or):				
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ord	w require been si						2⊠No 3 Prob	· - U
al Rec	: The law cate has t page 2 s	Completed				24a. Was an autopsy performed	prior to con death?	osy findings available inpletion of cause of
Z Z	ysicien: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 💢 Yes 2 □ No Hospital: 1 □ Inpatient	ER/Outpatient	Othor	eath (Check only one)	0.500	
اه ر	g Physier this	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?	Home 5 Residence	injury occurred	
Sior	eath. or: Aft	catio	2 Accident investigation 2/24/04	12:40 1	7 M 1 ☐ Yes 2 ☑ No		ATOR HIT B	
Σ̈́	s after d	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · At hor building, etc. (Specify, STREET)	me, farm, stre	et, factory, office	28f. Location (Stree City or Town, S 3d Ave & CnA	it and Number or Rura. State) CLESTON AVE	Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know 2 Medical Exeminer: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the time, date and placestigation, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier		29c. License number		Date signed (Month, L	
,	L		r west c	20-1/7	O.C.M.E.	M	arch 01, 2	JU4
			30. Name and address of person who completed cause of death (Item  AMA RUBIO, H P		nn Street, Balti	more, Mary	land 21201	
Ü	Sta		31 Date filed (Month Day Year) 32 Begistrar's Signati	ure				
4	Registr	ar	MAR 0 4 2004 Server	- AS	Boortes			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 06812 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** ANNABELLE A WORKING 9:20 A M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL ANNAPOLIS SPA CREEK CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
August 12, 15 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 ☐ F Yrs. 83 Director 296-07-9674 Barberton, OH Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examinar must be notified at Annapolis 1 XYes 2 No Anne Arundel Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 23a or 21401 85 Manresa Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or item eny injury or other traumatic event. The Mental of 18 page. 1 ☐ Yes 2 KMNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2(X) No Specify: White 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED BRACE&SUPPORT INDUSTRY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unknown) Zusannah Paul Yenek 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2046 Forest Hill Lane 19a. Informant's Name/Relationship (Type, Print) Sandra Corwin Crofton Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition K∑ Burial 2 ☐ Cremation 3 ∑Removal from State \* 4 □ Donation 5 □ Other (Specify) GreenLawn Cemetery March 9, 2004 Akron, Ohio 21. Signa 27 NARO FUNERAL HOME, P.A. GREGURY FINK M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate the sequence of the Due to (or as a consequence of) Examiner burial-transit be executed the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by , page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Hospital 29a. Certifie Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 04

32. Registrar's Signature

Chyd on

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 28a, c.e. per Dr. G829,03/04/04dhb

Amend Item #30 per dvr G828 2/25/04 cas

Certificate of Death

Reg. No. 2001 Reg. No. 2004 For A State A Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 50 AM Month Dav Year Physician HELMA LIMMSEMAN 2004 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner WIVERSITY OF MARYLAND Baltimore
If Under 1 Year If Under 24 Hrs. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 M 2 K Months 216-10-Yrs. Director 29 Maryland Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No allston JAD Directo Harford the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2104 HIUSBORD 238 Funerai 1210 U.S.A. death Items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 2XNo Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: Specify: Specify: þ 3 Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 **Housewife** Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Frederick Otto Scharf ဨ Rose Bretzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emory D. Zimmerman (husband) 1210 Hillsboro Court - Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot ang injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 02/25/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility E. F. Lassahn Funeral Home, P.A. assaln 11750 Belair Road - Kingsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition AKDIOGEIVIC resulting in death) /Medical (or as a cons uence of): Examiner Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy detached for in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 XUnknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 2 No certificate 1 Tyes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Unpatient ို 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (M. nth, Lay Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred after death. Certification: 5 Pending investigation 1 Yes 25 No 2 Accident 28e. Pla e of Injury - At I ome, farm, street, factory, office builting, tc. (Specify) 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide HUPSING To the Hospital within 24 hours a To the Funeral ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P00601 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto., MD 21201 22 S. Greene St. Anila Bhatti 32. Registrar's Signature 5 2004 State Registrar

State of Maryland / Department of Health and Mental Hygiene, 06814 For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** March 2004 Mahmut N. Atay 8:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 12 Crestmont Drive Aberdeen Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Jan • 1, 9. Birthplece (State or Foreign Country) Turkey 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 XM 2□ F Months 494-44-4197 78 Director Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural; or Itams 23a or 28a-f show any njury or other traumatic event. Its Madical Examined must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Aberdeen Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21001 12 Crestmont Drive by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes XXNo Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical 12th 5+ Physician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emine Delibasi Hulusi Atay 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Crestmont Drive, Aberdeen, MD 21001 Perihan H. Atay/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Buriat 2 ☐ Cremation 3 ☐ Bernoval from State MD National Mem. Pk 3/5/2004 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 313 Talbott Avenue, Laurel, MD 20707 anu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician 3 days Due to (or as a consequence of): resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed and sician at burial-t Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending physic IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 4 No 3 Probably 4 Unknown 1 TYes Completed Deed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? certificate 1 ☐ Yes 2 🖵 No. or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Hesidence 6 Other (Specify) 10 1 Yes 2 → No 2 ER/Outpatient 3 DQA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☑ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide in by t Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 omeleted cause of death (Item 23a) (Type, Print)

52.0 U 21015 520 Upper Chesapeake Drive, #211, Bel Air, MD Day, Year) 0 5 2004 32. Registrar's Signature 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2004 Claine Beecham larch of /Medical 4a Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Martin Catonsville BALTIMORE If Under 24 Hrs. 8. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year **Funeral** Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1 M 2 F Days Director 06/12 should be filed within 72 hours after death with the Marylend nd Mentel Hygiene.

marked other than "natural; or items 23s or 28s-f show 10a. State 10b. County permit. Peges 1 and 2 should be filed within 72 hours after death with tha Maryler Department of Health end Mentel Hygiene. Important: If item 27 is merked other than "natural", or frems 23s or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Baltimore Director Catonsville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Choice Vaiden 21228 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: To Be Completed by Specify: BLACK 3⊠Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance 12th Baltimore Public Schoo 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wesley Marie Peges 1 and 2 should bent of Health end Men Ihompson 19a. Informant's Name/Relationship (Type, Print) DAUGHTOD 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Road Baltimore MD Gun 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 39104 edar Baltimore 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vayahn C. Greene Funeral Services 5/5/ Baltimore National Pike Baltimore MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Finel disaase or condition resulting in death) Examiner Completed by Physician/Medical Examiner tor: After this certificata has been signed by the ettending physician and the funeral director, paga 2 should be detached for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Nos 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificata to complatally filled in by the funeral director, pag. 1 Tes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 D Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as steted.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASKEREN 31. Dete filed (Month, Day, Year) 32. Registrar's Signetur State Registrar MAR 0 5 2004 DHMH 16 Rev 6/95

	1 - For State Registrar		State o	of Mary	/land /	Depa <i>Cei</i>	artme <i>rtifica</i>	ent of F ate of	lealth and <i>Death</i>	Mental H	ygie Reg.		04	068	316
	Decedent's Name (First, Midd	de, Las	nt)							2. Date of 0	Death			3. Time o	f Death
1		R	ichard	K. C.	larke					Month Marc	h 2	Day 200	Year 14	3:35	РМ
l r	4a. Facility Name (If not institution	on, give	street and nu	ımber)			4b. Ci	ty, Town, o	r Location of Dea	-		4c. Coun			
	Andrus House						]	Bethe	sda			Mor	ntgom	10°W	
	5. Social Security Number	6. Se		7. Age (II	n yrs. last b	irthday)	If Und	der 1 Year	If Under 24 Hr Hours Mir	s. 8. Date of 6	Birth		9. Bir	thplece (State	or Foreigi
	017-16-3208	1.	<b>⊠</b> M 2□F		80	Yrs.	Month	ls Days	nours Mil	May 8	19	23		sachuse	etts
	Usual Residence of Decedent			140	- Ot - F-										
	10a. State 10b. Count	У		1 "	C. City, Tov	wn or Lo	cation							10d. Inside C	ity Limits 2 ☑ No
	Maryland Mont	gom	ery		Bet	thes	_				,				200140
	10e. Street and Number						10f. 2	Zip Code			10g.	Citizen of	f What Co	ountry?	
	5608 Oakmont	Ave						208				nited			
,	11. Marital Status		12. Was Dec Armed Fo	orces?	r in U.S.	13.	Was Der	cedent of h pecify Cubi	lispanic Origin? ( an, Mexican, Pue	Specify Yes or firto Rican, etc.)	10-		ace - Ame ack, Whit	erican Indian, e, etc.	
	1 Never Married 2 Ma		1 ⊠Yes If Yes, Gi	ve			1 🗆 Yes	2 🙀 No	Specify:			Spec	ity: Wi	nite	
3	3 ☐ Widowed 4 ☑ Divorce			Dates: WW		. D	dd 1.1.				1 401	16-1-1			
be completed by I diferal Difector	15. Decede (Specify only high	est gra	de completed)		168	(Give	kind of	sual Occup work done Fuse retired	during most of w	orking		. Kind of	DUSIÑOSS/	rindustry	
	Elementary/Secondary (0-12)		College (	1-4or 5+)			ulta		-/			aper anuf <i>a</i>	0+11-	or	
5	17. Father's Name (First, Middle	Last)				20118	итьс	311 C	18. Mother's Na	ime (First, Midd				EL	
í	Richard Clar	-								Mildred			,		
-	19a. Informant's Name/Relation		Type Print!		10	b Mailie	a Addre	ec (Street	and Number or F					Zin Codol	
				1. 4											
9	Kathleen C. Ki	LZI	iger/Da		20b. Place				Avenue,	Date				ZUSI/ Town, State	
	1   Burial 2 □ Cremation			State	cemete	ery, cren	natory o	r other plac		ch 6,	M.				
	*4 □Donation 5 □ Other (				St. Ma	_				.004	$\overline{}$			Connec	
	21. Signature of Funeral Service	e Licen	500	MO	00198	Da	1	_ A	ss of Facility Pumphrey sin Ave.	Funera	1 H	ome/I	Sethe Ch	sda-Ch 3501 In	evy
	23a. Part1. Ent the disease, of shock, or heart failure. Lis	or comp	olications that	caused the	death. Do								0014	Approximat Interval Bet	te
	Immediate Cause (Final	st Orny			Thro	mhos	eie							Onset and	Death
	disease or condition resulting in death)	-	a		onsequence									5 minu	tes
		•		,		,	Car	diova	scular I	)isease				30 Yea	rs
	Sequentially list conditions, if any, leading to immediate	,	b		onsequence									30 104	
	cause. Enter Underlying Cause (Disease or injury	1													
-	that initiated events resulting in death) Last		Due to	(or as a co	onsequence	of):									-
		ı	d												
			J									_			
	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, ou				-					23d. D	ate of del	ivery	
	in the past 12 months? 1 □ Yes 2 □ No		4 ☐ Preg	nant at tim	Fetal death			pregnancy (specify)				M	lonth	Day	Year
	9 Dunknown		9□ Unkn	nown											
	Part II. Other significant condit	tions c	ontributing to d	leath but n	ot resulting	in the u	nderlying	g cause giv	en in Part I.	23e. Dio	tobac	co use cor	ntribute to	the cause of c	death?
1										10	] Yes	2 <b>X</b> No	3 🗆 Pr	obably 4 🗆 l	Unknown
										24a, Wa	s an	24h	Were au	itopsy findings	available
							aut	opsy formed	17	prior to death?	completion of c	ause of			
	25. Was case referred to medic examiner?		Hospital:					O++		ath (Check only	-			F.F	
	1X Yes 2 No		1 📙	Inpatient	2 ERVO				4   Nursing	Home 5□Re				city)Group	Hom
	27. Manner of Death 1 X Natural 5 ☐ Pend			of Injury oth, Day Ye	ear) 28b.	Time of Injury		28c. Injur Wor		28d. Describe	now i	njury occu	irred		
3	2 Accident inves 3 Suicide 6 Could	tigation					М		Yes 2 □ No		-				
	4 Homicide deter	mined	28e. Place build	e of Injury ling, etc. (S	- At home, f Specify)	arm, str	eet, fact	ory, office		28f. Location City or T			ber or Ru	ıral Route Num	ber,
medical certification.															
1	(Check only 2   Medica	ing Ph u Exam	nner: On the t	pasis of ex	amination ai	e, death	occurre estigation	ed at the tir	ne, date and place pinion, death occ	e, and due to the	e cause , date	e(s) and mand place	anner as	stated. to the cause(s	()
	one)  29b. Signature and title of certific		and mar	ner stated	l.			9c. Licens						h Day Year)	

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director:

Division of Vital Records, P.O. Box 68760,

**Physician** /Medica Examine

**Funeral** Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "natural", or Items 23a or 28e-f show eny injury or other traumatic event, the Madical Estiminar must he perfect that any other traumatic event, the Madical Estiminar must he perfect that any other traumatic event, the Madical Estiminar must he perfect that are also that the perfect that the perf

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

MAR 0 5 2004

30. Name and address of person who completed

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Robert F. Byrne, M.D. 2333 South Nash Street, Arlington, Virginia 32. Registrar's Signature

e of death (Item 23a) (Type, Print)

**ORIGINAL** 

29c. License number

D0009314

29d. Date signed (Month, Day, Year)

March 3, 2004

State of Maryland / Department of Health and Mental Hygiens 06817 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 **Physician** Caroline Α. Carroll March 2, 14:05 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harbor Hospital Center Baltimore N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 29, 1917 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 3 → F 213-10-1326 86 Yrs. Director MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show a avent. Ite Medical Evantiner must be notified at N/A MD Baltimore City XXYes 2 □ No Director 10e. Street and Number 1305 Decatur Street 10f. Zip Code 10g. Citizen of What Country? 21230 USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mertal Hygiene. The file of Health and Mertal Hygiene. The smarked other than "natural; or the ury or other traumatic avent, the Medical Evantmentry or other traumatic avent, the Medical Evantment. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à Specify: white 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Hairdresser Hair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Max Kehm Katherine Rosenauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Katherine A. Finley /Daughter 1516 E. Fort Avenue, Baltimore Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Cross Cem. March 6, 2004 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages:
Department of H
Importent: if Ite
any injury or of \*Burial 2 Cremation 3 Removal from State Baltimore Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. victor P. Doda, Jr. 1501 Fast Fort Avenue, Baltimore, MD 21230 Approximate Interval Between Opset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ventruile Physician Im medat /Medical Due to lar as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? 2 -NO 1 Yes 2 NO 1 Tes or Attending Physicien; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Beath 1 Natural 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Descritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 30555 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back, MB 21230 E. Fort Ave. lan Ni wo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State o	f Marylan	d / Depa <i>Cei</i>	artmen rtificat	t of H e of L	ealth and I Death	Mental Hy	giene Reg. No	2004	06818
			Decedent's Name (First, Middle,	Last)						2. Date of De	eath Da	ıy Year	3. Time of Death
	Physic /Med			Shun L.	Chen						ry 2	28, 2004	6:45P M
	Exam		4a. Facility Name (If not institution,	give street and nur	nber)				Location of Death	1		. County of Death	
		×	4400 Falcon Stre						7111e If Under 24 Hrs.	10.0-1-40		Montgome:	<del>-</del>
	Funera			5. Sex 1 ☐ M 2 <del>Q</del> F	7. Age (In yrs. 88	• • •	Months	Days	Hours Min.	8. Date of Bi (Month, D Aug • 2	rtn ay Year ) ່າ	1915 Ind	iplace (State or Foreign intry) Onesia
1	Directo	r	218-45-4254 Usual Residence of Decedent	- Λ	00					Aug. 2		I JI J III U	JIIESTA
2	laryland show		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	Mary Fed	ţo	Maryland Montgo	omery		Rockv	7ille						1 ☐ Yes 2 💆 No
15	th the Mi or 28a-f	le o	10e. Street and Number				10f. Zip	Code			10g. Ci	itizen of What Cou	untry?
2.	th wit	Funeral Director	4400 Falcon Stre	eet				208				ited Sta	
9	ter dea Items	nei	11. Marital Status	Armed Fo		.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	14. Race - Amer Black, White	
	36 s afte	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	d 1 ☐ Yes II Yes, Gir Year or D	/e		1 🗌 Yes	2 <b>X</b> No	Specify:			Specify: AS:	ian
-	d 21215-0036 Higiene within 72 hours after death with the Maryland Higiene. The market han "natural", or Items 23e or 28e-f show ont, the Medical Francher must be notified at	pa	15. Decedent's			16a. Dece	dent's Usu	al Occup	ation		16b. l	Kind of Business/l	ndustry
7	15 nin 72	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (	1-4or 5+)	(Give	kind of wo DO NOT u	se retired	during most of word)	rking			
1	d 212 filed with Hygiene. other the	Completed	8	Conogo (		Нс	omemal	ker				Home_	
25	be filed that Hygod other	Be	17. Father's Name (First, Middle, L	ast)					18. Mother's Nar	ne (First, Middle	e, Maide	n Sumame)	
10	larylan	2	San Long Chen						Njie Moy				
N	re, Maryland s 1 and 2 should be file Health and Mental Hy tem 27 ls marked oth other traumatic even		19a. Informant's Name/Relationsh				-		and Number or Ru				ip Code)
Q	e, No 1 and 1 and 1 dealth am 27 that that the		Lanni Wiguna/Dat	ighter	20b. F	Place of Dispo cemetery, cre			Street; I	Date		ocation - City or	Fown, State
0	Baltimore, Dermit. Pages 1 at Department of Hea mportant: If Item any injury or otha		1 Burial 2 X Cremation		State				1	02/2004	D.o.	1+0771110	MD
Q	Baltimol permit. Pages Department of Important: If eny injury or	شد	'4 □Donation 5 □ Other (Sp 21. Signature of Funeral, Service L	100	Che				ory   03/ ibute Fur				
	Baltimore, Mapermit. Pages 1 and 2 Department of Health a Important: If Item 27 Is eny injury or other tra	Buc	Writing	X Vil	Me c		1mp16	Rocky	ville Pil	neral an ke; Rocl	na Ci kvil	remation le, MD 20	0852
		3.	23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that	caused the deal	th. Do not en	ter the mo	de of dyin	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physicia	n	Immediate Cause (Final disease or condition			erebro	าบลระเ	ılar	Accident	٠			Onset and Death
	/Medica	al	resulting in death)		(or as a consec		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			-			
1.1	Examine	30	Securitielly list conditions.	D	al Fibr		ion						
All	Si Bd	line	Securities list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence ot):							
G.	xecut and	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):							
	Box 68760, eath certificate be executed attending physician and ifor use as the burial-transit	calE											
	OX 68760  h certificate be ending physiciar	edic											
	OX h cert	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		itcome of pregn		□Ectopic p	regnancy	v			23d. Date of deli	
2	O. BC Ne death the atter	Sicia	in the past 12 months? 1 ☐ Yes 2 X No		nant at time of o		Other (s					Month	Day Year
17	S, P.O. es that the de igned by the	h,	9 Unknown			. Marine to all a			and Dead	220 Dia	Lobacco	ueo contributo to	the cause of death?
T		b	Part II. Dther significant condition Hepatitis	ns contributing to d	leath but not res	suiting in the t	underlying	cause giv	ren in Faiti.		Yes :		obably 4 Dunknown
0	Or Or requirements	eted											terry findings syallable
**	2 B S S	Completed	Type 2 Diabetes							24a. Wa aut per 1 🗌 Yes	ODSV	prior to d	topsy findings available completion of cause of
	a Th	ပိ							00 Bloss of Do			lo 1 ☐ Yes	2 No
	Vital Sician: Certifica	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital:	Inpatient 2	TER/Outpatie	ant 3 🗆 D	OA Oth	26. Place of De			6 DOther (Spe	rify)
Z	Of Phy or this aral d	F.	27. Manner of Death	of Injury oth, Day Year)	28b. Time		28c. Injui Woi		28d. Describe			2.,,,	
7	ISION Ision Itending death. Itor: After	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investig		iii, Day 10ai)	injury	М		Yes 2 □ No				
1	Vision Attended to the by the	Certification:	3 Suicide 6 Could r 4 Homicide determi	nod 200. Flau	e of Injury - At h	nome, farm, s	treet, facto	ry, office		28f. Location City or T	(Street a	and Number or Ru ite)	ıral Route Number,
V	Div ital or A rral Direc	Ser								L.			
	Division of Vital Re Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the Examiner: On the i	e best of my kn basis of examin nner stated.	owledge, dea ation and/or i	ath occurred investigation	at the ti	me, date and plac opinion, death occ	e, and due to th urred at the time	e cause( e, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	thin 2 the othe	Med	29b. Signature and title of certifier		iller stated.	1	25	c. Licens	se number		29d. D	ate signed (Monta	h, Day, Year)
	\$ ± ₹ 5		> Mulas	2		MD		D51	724		M	arch l,	2004
			30. Name and address of person	who completed cau	use of death (Ite	em 23a) (Type	Print)	101	<i>,</i> 4 1		1.10	arch 19	
	Q		Neelam Shah, MD					; Ke	nsington	, MD 20	895		
		State	31. Date filed (Month, Day, Year)	nature	hoes								
	Rea	istrar	m	5 2004	Jest Jaklatins	15	ARRIVE	A. S.					

State of Maryland / Department of Health and Mental Hygien Q O I

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			1- State Registrar	Cei	rtificate of Death		ierie UU4	06819
	Physici		1. Decedent's Name (First, Middle, Last)  Robert Wesley		Doms	2. Date of Death Month March	Day 2004	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 2305 Eastlake Rd.		4b. City, Town, or Location of Death		Baltimor	eth .
	Funeral Director		473-24-9485 10XM 20F 74	yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Pay, Dec. 03	уеаг) 1929 М1	rthplace (State or Foreig ountry) nnesota
	Maryland -f show	tor	Usual Residence of Decedent	c. City, Town or La				10d. Inside City Limits
	sa or 28a	I Director	10e. Street and Number 2305 Eastlake Rd.		10f. Zip Code 21093	10	Og. Citizen of What C	ountry?
036	hours after death with the Maryland tural', or Items 23a or 28a-f show al Exerciting the rediffed at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Eve Armed Forces?  1 Never Married 2 Married  17. Was Decedent Eve Armed Forces?  1 Never Married 2 Married  18. Was Decedent Eve Armed Forces?  1 Never Married 2 Married  19. Was Decedent Eve Armed Forces?		Mas Decedent of Hispanic Origin? (Spt Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	erican Indian, te, etc.
Maryland 21215-0036	CI 65 UI	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) +5	(Give	ient's Usual Occupation kind of work done during most of work DO NOT use retired) Colonel	king	16b. Kind of Business	
yland ;	Menta Menta arked	To Be C	17. Father's Name (First, Middle, Last) Wesley Doms		18. Mother's Nam Hester	e (First, Middle, M Rydeen		
e, Mar	l and 2 sho lealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print) Mrs. Grace Doms/ Wife	2305	Eastlake Rd. Time	onium, Mo	1. 21093	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to once.		'4 □Donation 5 □Other (Specify)	Hilltop :	Service Co. 3-4-(	D4 T	Oc. Location - City of	
Bal	Depar Impor any in		21. Signature of Funeral Service Licensee		Ruck Towson Funer 1050 York Rd. Tow			
	Physician /Medical Examiner		resulting in death)  Due to (or as a co	schani	er the mode of dying, such as cardiac  Leat Dis		st,	Approximate Interval Between Onset and Death
68760,	tificate be executed ig physicien and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition of the cond					
O. Box	that the death certif ed by the attending detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy		23d. Date of de Month	livery Day Year
Records, P.	ing Physician: The law requires h. After this certificate has been sign funeral director, page 2 should be	by	Part II. Other significant conditions contributing to death but no	ot resulting in the un	nderlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
al Reco		Completed				24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of 2 No
ion of Vital		tlon: To Be	25. Was case referred to medical examiner?    Yes   2 No	2 ER/Outpatien 28b. Time of Injury	Other: 4 Nursing Ho	th (Check only one)  The State Resider  28d. Describe how	nce 6 Other (Spe	cify)
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - building, etc. (S	At home, farm, stre	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only ane)  Check only and bits of extifier.	y knowledge, death imination and/or inv	estigation, in my opinion, death occuri	red at the time, dat	te and place, and due	to the cause(s)
	X\ 82₹2	~	29b. Signature and title of certifier	> ws	D003886	8	d. Date signed (Mont	2004
	10		30. Name and address of person who completed cause of deals Charles Winterwitz MO	(Item 23a) (Type, I	D. Joppa RO Su	te 306	Lutters	CM, WD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 0 5 2604

		1 - For Amend Item 8 State RegistrarAMFND ITE	M_#20b	er FH,G8 PER FH G	3 <b>29,0372</b> 4/ 3 <b>29</b> 3/05/	04dHb 04 GA	tificate o	f Dea	th		Reg. No	200	) [4	0682
Physici	an	Decedent's Name (First, M  Johanna	iddle, Last)	Delane						2. Date of De	aath Da	y Y	ear /	3. Time of Death
/Medic		4a. Facility Name (If not instit	ution, give str				4b. City, Town	, or Location	on of Death	7550	ugre 4	County of	Death.	1622
	K.	IEMINSHIM IICH.	what i	nedient	CONTA	/		161364			-024	Nico		
Funeral Director		5. Social Security Number 120–28–7194	6. Sex	M 2 <b>∑</b> F 7.	Age (In yrs. last	Vrs.	Months Day		for 24 Hrs. s Min.	(Month, Da	ay, Year	26/ <i>31</i> 9. 937	Birthpla Count	
pu »		Usual Residence of Deceden								TOLIL .				
Marylan f show	lor	MD Wor	œster		10c. City, To	own or Loc		an Cit	zv.				10	d. Inside City Limits Yes 2 No.
th with the M 23a or 28a-f	I Director	10e. Street and Number 177 Sout	h Ocean	Drive			10f. Zip Code	218	342		10g. C	itizen of Wha	t Count	ry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Healin and Mental Hygiene. It of Healin and Mental Hygiene. It has 27 is marked other than "natural", or items 23a or 28a-f show of other traumatic event, the Medical Exaginar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 XX	Marned	2. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	XXIIo	l If	Vas Decedent of Yes, specify Cu	ıban, Mexi	can, Puerto	pecify Yes or No Rican, etc.)	>-	14. Race - Black, Specify:	White, e	
within 72 ho ene. than "natur he Medical	Completed	(Specify only his Elementary/Secondary (0-1		completed) College (1-4		(Give k	ent's Usual Occ and of work don O NOT use reti	e during n	nost of work	ang	16b. F	(ind of Busin	ess/indu	ustry
Hygiene. bther then		12 17. Father's Name (First, Mid	dle (ast)	0			Secretar	-	ther's Nam	e (First, Middle		exaco		
and Mental Hygiene. is marked other than sumatic event, I'm M.	To Be	Patrick						13.140		Hanna E				
and Men is marke aumatic		19a. Informant's Name/Relat				9b. Mailing	Address (Stree	et and Nur	nber or Ru	al Route Numb	er, City	or Town, Sta	te, Zip C	Code)
of Health item 27 rother tra		Joseph D  20a. Method of Disposition	elaney /	/ Husban			177 South	Ocean		, Ocean C				- 21-1-
ury		1 Burial 2 Cremati  4 Donation 5 Othe	on 3 JaRer r <i>(Specify)</i>	moval from Sta	ceme	itery, crem	atory`or other pi			₩3/27/0 <del>23, 200</del> 4			y or Iow	m, State
Departimonal Important in any in once.		21. Signature of Fune.	ce Licensee	Victor	Doda	a a	Name and Add	Steve	ns Funa	eral Home Baltimor	~ MO	21220		
hysician /Medical Examiner	i Examiner	23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	Due to (or Bill	as a consequence  as a consequence  as a consequence  beteral  as a consequence	(y f (x oi): (x = oi): (x = oi):	who his	>im	as cardiac	or respiratory a	rrest,		1	Approximate niterval Between Driset and Death Conset and Death Cons
ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	1 ☐ Live birth	me of pregnancy n 2 ☐ Fetal dea t at time of death n		Ectopic pregnan Other (specify)	су				23d. Date of Month		r Pay Year
quires ina in signed l uld be det		Part II. Other significant con	ditions contr	buting to deat	h but not resulting	g in the une	derlying cause g	given in Pa	rt I.	23e. Did to			te to the ] Probat	cause of death?
cate has been s page 2 should	Completed by	Diales Hyper	tens:	00								prior	to comp h?	y findings available detion of cause of
this certificate	Be	25. Was case referred to med examiner?		spital:			0	ther		h Check on a				
death. :tor: After this :the funeral di	tlon; To	1 Yes 2 No  27. Manper of Death 1 Natural 5 Per 2 Accident inv	-	28a. Date of I (Month,		Dutpatient  Time of Injury	28c. Inju	4 🗆		me 5 Resid			Specify)	
	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be ermined	28e. Place of building,	Injury - At home, , etc. (Specify)	farm, stre	et, factory, office	Э		28f. Location (5 City or Tox	Street ar vn, State	nd Number o	r Rural I	Route Number,
within 24 hours after of the transfer of the t	Medical C	29a. Certifier 1. Certifier (Check only one)	fying Physic cal Examine	cian: To the be	est of my knowled s of examination a stated.	lge, death and/or inve	occurred at the estigation, in my	time, date opinion, d	and place, eath occurr	and due to the red at the time,	cause(s)	) and manne d place, and	r as stat due to th	ed. ne cause(s)
within To th comp	Me	29b. Signature and title of cer	tifier	0.	a.M			nse numbe			29d. Da	te signed (M	onth, Da	y, Year)
		) O. H. Kess	Er Jak	all	1		Do	060	715					12004
		30. Name and address of persons Seyed Ha	101-603	ea Jak	ali 100	Eas	tint)	11st,	Sali	sbury,	mD	316,	oj	
Sta Registr		31. Date filed (Month, Day, You MAR 0	5 2004	32. Reg	istrar's Signature	A.	well							

Johanne Delaney

			1 - For State Registrar	State of Marylar	id / Depart <i>Certi</i>	tment of H	lealth and Death		giene (	2004	06821
m	5		Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Physici		MARGARET	LIDSTIA	De	A. T. P. S.		Month Fr BRV	Day 2	Pack Si	10:00 PM
,	/Medio		4a. Facility Name (If not institution, give s	treet and number)	4	b. City, Town, or	Location of Deal	1. 30.		County of Death	
	- LAGITIII		STILA PARIS HO	P.173	B though	Timen	mail		B	mille	ORS.
	Funeral		Social Security Number     6. Sex	7. Age (In yrs.	N N	If Under 1 Year Months Days	It Under 24 Hrs Hours Min.		th	9. Birthp	lace (State or Foreign
	Director		914 1P 3d10	M 200 F 86	Yrs.			A66.17	1013	MAR	MARO
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Local	tion				1	0d. Inside City Limits
	Aaryla f sho	ō			mille						1€ Yes 2 No
	the the tage of the tage of the tage of tage o	Directo	10e. Street and Number	101	4711016	10f. Zip Code			10g. Citiz	en of What Cour	itry?
	With With	0	5406 HILLBURG	AVE		212	111		1	D.C.A.	
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or itema 23a or 28a-f show event, I're Medical Examinar must be notified at	Funeral		2. Was Decedent Ever in U	.S. 13. Wa	s Decedent of H	ispanic Origin? (S	Specify Yes or No	1.	4. Race - Americ	
٥	after or ite		t ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		es, specify Cuba ]Yes 25⊠ No	in, Mexican, Puer Specify:	to Rican, etc.)		Black, White,	etc.
15-0036	ral',	d by	<b>3</b> Widowed 4 □ Divorced	Year or Dates:	'	1162 20M140	Specily.			Specify: WH	1115
ה	72 h natu	Completed	15. Decedent's Educ (Specify only highest grade		(Give kin	it's Usual Occupi of work done	during most of wo	rking	16b. Kin	d of Business/inc	dustry
2	vithin han	귵	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retired	")			00	Abency
N	filed with Hygiene. other ther		17. Father's Name (First, Middle, Last)		1 120	< P	18. Mother's Na	me (First, Middle			THOU ILY
au		Be c	11-0000	WIEGHA	770		1 40	0 0-	-11-	510 -	
Maryland	s 1 and 2 should be filed within I Health and Mental Hygiene. Item 27 is marked other than other treumatic event, tha M	ဥ	19a. Informant's Name/Relationship (Type			Address (Street a	and Number or R	ural Route Numb	er, City or	Town, State, Zip	Code) 21013
<u> </u>	. m on =		STACI VIONE		174100	BOIN.	DO CTA	Rosa	Bal.	1506	lachano
<u>ဂ</u> ်	s 1 and 3 I Health Item 27 other tr		20a. Method of Disposition		Place of Dispositi cemetery, cremat	on (Name of	a leas	Date	20c. Loc	ation - City or To	wn, State
e E	Pages net of int: If it		D Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	MECLIE!	Constant of the control of the contr	)   1	-127	PAIS	TOPES !	CAR ARA
	permit. Pages 1 and 2 Department of Health & Important: If Item 27 i any injury or other tre once.		21. Signature of Funeral Service License	0	-22. N	lame and Addr	St of Facility	THEFT	-s.Raj	+5250	ATTO CHAR
ñ	Per		> LAND THOSE		53	TER D	125 YORK	ROAD T	118000	Tive !	IARILAND
4	TA BOT		23a. Part1. Enter the disease, or combits shock, or heart failure. List only of	cations that caused the deat	h. Do not enter	the mode of dyin	g, such as cardia	c or respiratory a	rrest,	1	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1	ovice	Hoor	/ /	ive			Onset and Death
8	/Medical		resulting in death)	Due to (or as a consec		1160	-				
	Examiner		Sequentially list conditions, b	Acy	chen	el to	.lese				
	D #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	uence of):						
	ecute and -trans	Gam	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	ters, v	Y					
60,	sate be executed physician and the burial-transit			Due to (b) as a consec	dence or).						
8760	The law requires that the death certificate be executed to has been signed by the attending physician and vage 2 should be detached for use as the burial-transit	dlcai	d			· · · · · · · · · ·					
9 X	leath certific: attending pl	Physician/Me	IF FEMALE:	3c. If yes, outcome of pregna	ancy				23	3d. Date of delive	rv
Вох	atter I for u	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta		ctopic pregnancy ther <i>(specify)</i>				Month	Day Year
o.	that the de ed by the detached	ysi	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	9 Unknown		.,,,,,,					
٠ <u>٠</u>	s that ned b e deta	by PI	Part II. Other significant conditions con	tributing to death but not res	ulting in the unde	erlying cause give	en in Part I.	23e. Did t	obacco us	e contribute to th	e cause of death?
rds	w requires that s been signed to should be det		Accie					10	Yes 2 €	No 3 □ Prob	ably 4 □Unknown
000	s bee	Completed	Bort Gol	5. n. of toe	6			24a. Was		24b. Were auto	osy findings available inplation of cause of
Ä	The lav	Eo						autoj perfo	rmed?	death?	2 No
		Bec	25. Was case referred to medical				26. Place of De	ath (Check only o			
>	Physic this ce al direc	To	examiner? 1 ☐ Yes 🎏 No H	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA Othe	er: 400 Nursing I	Home 5 ☐ Resi	dence 6	Other (Specify	)
0	ng Pl		27. Manner of Death  ↑★Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World	/ at k?	28d. Describe	how injury	occurred	
S	Attendii death. ctor: A y the fu	catl	2 Accident investigation				Yes 2 □ No				
Ë	fter d lirect n by	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street ly)	t, factory, office		28f. Location (		Number or Rura	I Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director;		20a Cadifica	Inlant To the best of and	uulade- dt-		no date and all	and district			
	Hosi 24 ho Fun Fun	edical	29a. Certifier (Check only one)  Certifying Physical Examination  (Check only one)	ician: To the best of my known er: On the basis of examination and manner stated.	owiedge, death of ition and/or inves	ccurred at the tin stigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time,	date and p	ind manner as st place, and due to	ated. the cause(s)
	o the o the omple	Med	29b. Signature and Mile of certified	und mainor states.		29c. License	e number		29d. Date	signed (Month, i	Day, Year)
	⊢ 3 ⊢ ŏ		X			n	5-328	3			
			30. Name and address of person who co	moleted cause of death /Item	n 23a) (Type Pri	int)			0 18/1	5 KH1	4004
	#		LLT. r lo L47 J	Tr4 112 .11:	17 Son	EL 110	- 115	Sypan	15-1	to me	1004
	Sta	ite	31. Date filed (Month, Cay Man )	2 Registrat's Sign.	ature &	A					, - 0 - 0 -
	Regist		111/11/10	LUUT SECRETA	Se St.	ARTIS SEL					

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760

of Vital Records,

Division

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 1 - State Registrar 06823 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:40 AM VORAK 29 2004 HUGUST HARLES TEBRUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PPER CHESAPEAKE MEDICAL CENTER FALLSTON
If Under 1 Year | II Under 24 Hrs. ARFORD 8. Date of Birth (Month, Day, Year) MAY 27, 1928 9. Birthplace (State or Foreign Country)

MARYLAND 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 M 2 ☐ F Hours 20.0736 Yrs MAY Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. The Mudical Exercities maintitle notified at MARYLAND HARFORD 1 ☐ Yes 2 No BEL AIR Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 OURT LINWOOD Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1. M.Yes 2 No If Yes, Give Year or Dates: 1945 - 1940 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 25 Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) ANAGER - DATA PROCESSING Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WALTER HARL DVORAK 1 RAC€ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEL AIR, ELIZABETH IFE MD 21014 LOOWINI-OURT, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o ō 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \*4 ☐ Donation 5 ☐ Other (Specify) -6-04 FOREST HILL, MD 22. Name and Address of Facility EVANS FUNERAL CHAPEL. BELAIR 21. Signature of Funeral Service Licensee 3 NEWPORT DRIVE, FOREST HILL, MD 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Myocardial Interction Six Hous /Medical Due to (or as a consequence of): Examiner One Year Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a const uence and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal 1 Yes 2 No 3 Probably 4 Unknown Should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s this certificate has autopsy 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | XER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To filled in by the funeral dir e Hospital or Attending Ph 24 hours after death. e Funeral Director; After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29q. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 033642 cause of death (Item 23a) (Type, Print) 754 HICKORY AVENUE Beltor MD 2014 yder MD 32. Registrar's Signature 31. Date liled (Month, Day, MAR State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

190599

Charl

vorak,

State of Maryland / Department of Health and Mental Hygiene 2004 06824 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2:10A Thuong Ha Duong March 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Randolph Hills Nursing Home Wheaton Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🖾 F 83 14, 1920 Vietnam 586-58-6529 May Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County or 28a-f show item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar is just be notified at 1 ☐ Yes 2 1 No Director Maryland | Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4011 Randolph Road 20902 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status illed within 72 hours after 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Asian Baltimore, Maryland 21215-0036 If Yes. Give Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Shop Owner Self Employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fits Department of Health and Mental by Important: if item 27 is marked oth ery injury or other traumatic event one. Be Lam Duong Tho Thi Dao 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Pebble Beach Dr., Silver Spring, MD. 20904 Dien N. Duong / Niece 20b. Place of Disposition (Name of Montgomery crematory or other place)
Crematorium, Inc. March 6 2004 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bethesda, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pumphrey Funeral Home/ 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814 M01353 4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's Dementia Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trans and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physicien IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year detached for in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Senile Inanition 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2X No Certification: To 3 DOA 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the Fune completely fi (Check only and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ohe Vista. D08944 March 1, 2004 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 Farragut Avenue, Kensington, MD. 20895-2110 Martin C. Shargel, M.D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 5 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes 06825 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 29, February 2004 6:20A M. Bernice Delchamp /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Sunrise of Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | March | 11, 1917 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🗓 F 86 Yrs. Colorado 228-20-9788 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rai', or itema 23a or 28a-f ehow Exercites must be notified at 1 Yes 2 □ No Directo Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21401 United States 800 Bestgate Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2🗓 No Specify: Specify: þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) 4 Public Schools Teacher nt of Health and Mental Hygis If item 27 le marked other or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Lucretia Keller Norris S. Welch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21401 Albert W. Olmstead, III/Son 200 South Cherry Grove Avenue, Annapoils, MD 20b. Place of Disposition (Name of cometery, crematory or other place Parklawn Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition March 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If eny injury or 2004 4 □ Donation 5 □ Other (Specify) Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of meral Service Licens Pumphrey Funeral Home/ M00803 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa [Lisabe or irrjury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 2 X No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 💢 No 3 DOA Medical Certification: To inis the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No м death. after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Hospital 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D40519 March 1, 2004 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mirza M. Nusairee, M.D. 1667 Crofton Centre, Crofton, Maryland 31. Date filed (Month, Day, Year) State Registrar MAR 0 5 2004

State of Maryland / Department of Health and Mental Hygiene 2001 06826 For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** March 2, 16:10 2004 Margaret Prince Dennis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Calvert Manor Health Care Center Rising Sun

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | Cecil 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🔯 F 97 1906 Marvland Director 220-05-8126 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State r than "naturel", or Items 23s or 28e-f show the Wedlest Exemples must be notified at 1 ☐ Yes 2 No Director Maryland Bel Air Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 300 Sunflower Drive 21014 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify If Yes, Give Year or Dates: þ 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sales Lady Jewelry Store Ith and Mental Hygier 27 is marked other the r traumatic event, In 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: if item 27 is marked c any injury or other traumatic eve 90cs. Martha Virginia Lyons Edmund George Prince 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 E. Cecil Avenue, North East, MD 21901 Anne Wood / Daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grdns 3-4-04 Bel Air, Maryland 21. Signatur of Funeral Service License 22. Name and Address of Facility
McComas Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 50 W. Broadway St., Bel Air, Maryland 21014 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vascular accident Physician 2 weeks /Medical **Examiner** Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day ò 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ALZHEIMER' 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed' certificate or Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Division 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6058354 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rising Sun COLONIAL Way NEILE MD 101 31. Date filed (Month, Day, Year) #32. Registrar's Signature State MAR 0 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2001 06827 For Stete Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** OSIPM FEB 2004 Peri Derbigny /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SAINT AGNES HEALTH CARE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Months 1 □ M 2 🛱 F 07-14-1967 Maryland Director 219-0207106 36 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a. State or 28a-f show ust be notified at 1 AYes 2 No Director N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 21216 U.S.A. 3808 Clifton Ave Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items any injury or other traumatic event, the Medical Examination once. 1 ■Never Married 2 Married 1 Yes 24 No Baltimore, Maryland 21215-0036 Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Industry Waitress 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Gwendolyn Derbigny ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8866 Foxcreek Drive Stockton, California 95210 Caroline Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 03-08-2004 Bayview Crematory Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wise Funeral Services, P.A. 700 S. Beechfield Ave Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ENCEPHLOPATHY 10 DAYS **Physician** ANOXIC resulting in death) /Medical Due to (or as a consequence of) Examiner IODAYS OCCIPITAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner IMONTH H11V burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical as the IE FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Year in the past 12 months?
1 ☐ Yes 2 ☑ No Month ō Day 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 □ No PNUE MONTA 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 🗌 Yes 2 🗆 No 1 Yes Vital Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral dir o this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie P17597 MANMEET KAUR MD. Manuelt FEB 29 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANMEET KNUR ST AGNES HOSPHAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 5 2004

DHMH 17 Rev 1/2001

DERBIGNY

WAYNE FILIS UNK 04-052		1 - For State Registrar	;	State of Ma	ryland /		nent of F cate of		d Men	tal Hygiene		4 06828	
Physic /Medi		1. Decedent's Name (Firs	E	ELLI.	5				Fe		5, 200	4 2240 <sup>M</sup>	
Exami		4a. Fecility Mame (If not in 3000 block				4b.		r Location of C ltimore	€	4c.		N/A	
Funeral Director		5. Social Security Number  UNKNOWN Usual Residence of Dece	123	M 2□F	(In yrs. last 29	birthday) If I Yrs. Mo	Inder 1 Year onths Days	If Under 24 Hours	Hrs. 8. [ Min. 1 2	Date of Birth	1	rthplace (State or Foreign Country) AMACIA	
death with the Maryland rme 23s or 28s-f show	tor		. County PG		10c. City, T	own or Locatio	rTSVII	LE				10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
with the I	Direct	10e. Street and Number				10	Of, Zip Code			10g. Cit	izen of What C	Country?	
5 2 E	by Funeral Director	5731 29th  11. Marital Status  1 Never Married  3 Widowed 4	2 Married	2. Was Decedent E Armed Forces? 1 Yes, Give Year, or Dates:		If Yes	Decedent of h	20782 Hispanic Originan, Mexican, f Specify:	n? (Specify Puerto Rica	Yes or No-	JAMAC 14. Race - Am Black, Wh Specify:	rencan Indian,	
:1215-0036 within 72 hours aft ene. than "natural", or the Medical Exempton in Medical	Completed	15. [ (Specify on Elementary/Secondary	Decedent's Educative highest grade	ation completed) College (1-4or 5-		6a. Decedent's (Give kind life. DO N	of work done IOT use retire	during most of	f working	16b. K	ind of Busines	s/industry	
d 2121 filed within Hygiene. ther than "	To Be Con	1 2 17. Father's Name (First, Middle, Last) 18. Mother's Name								N/A e (First, Middle, Maiden Sumame)			
Maryland 2121: nd 2 should be filed within th and Mental Hygiene. 27 1e marked other than "		JOSEPH IRVING  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Num									or Town, State,	Zip Code)	
t. Pege trent or		Ingrid I  20a. Method of Dispositic  1 Burial 2 Cre 4 Donation 5   21. Signature of Funeral	on emation 3 □Re Other <i>(Specify)</i>		20b. Plac cem	e of Disposition etery, cremator ARET C	9th An (Name of ry or other pla EEMETE me and Addre	RY 03	-13-		MACIA	r Town, State	
Bal permi Depa Impo		21. Signature of Funeral Service Licensee 22. Nam					0 LIB e mode of dyi	ERTY ng, such as ca	HGHT	S AVE. I		MD21207 Approximate Interval Between	
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		HULTIPLE Due to (or as a	G	VNSHOT	- WC	2 CN VI				Onset and Death	
A MARINE TO A	Examiner	Sequentially list condition any, reading to immedicause. Enter Underlying Cause (Disease or injury that initiated events	ons, b.	Due to (or as a	1 consequen	nea of):							
68760, fificate be executed g physician and as the burial-transit	_	resulting in death) Last	d.	Due to (or as a	a consequen	nce of):							
Records, P.O. Box 68760 The law requires that the death certificate be each has been signed by the attending physician age 2 should be detached for use as the burinage 2	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									elivery Day Year		
rds, P. quires that t n signed by	þ	Part II. Other significant conditions continuously to dealin out not resulting in the underlying cause given in rate.								23e. Did tobacco	- 4	to the cause of death?  Probably 4 □Unknown	
Division of Vital Records, for Attending Physician: The law requires tatler death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed									24a. Was an autopsy performed?	prior to death?	autopsy findings available completion of cause of	
of Vital Physician: This certifical	o Be	25. Was case referred to examiner?		ospital: 1 ☐ Inpatie	nt 2∏EF	VOutpatient 3	B DOA Ot	has		hack only one) 5 Residence		pecity) SCENE	
Vision of Attending Phy r death: ector: After this by the funeral d	J=-	27. Manner of Death	Pending investigation	28a. Date of Injur (Month, Day 2/25/04	y 28	Bb. Time of Injury	28c. Inju		28d.	Describe how inju	ry occurred	67	
Divisio for Attendi after death Director: /	ertification:		Could not be determined	28e. Place of Injubulding, etc	ury - At home c. (Specify)	e, farm, street,	factory, office			City or Town State	a)	BACTIMORE,	

Medical Certification: To

To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. F.

RUBIO, MD

STREET

281. Location (Street and Number or Rural Route Number, City or Town, State) 3000 HANLON AVE, BALTINGE, MD

29a. Certifier

> 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

O.C.M.E.

29d. Date signed (Month, Day, Year) February 26, 2004

State Registrar

31. Date filed (Month, Day, Year) 2004

anol





30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A1/A KNB (O, FD) 111 Penn Street, Baltimore, Maryland 21201

	1	For State Registrar	State of Maryland	/ Depa <i>Cer</i>	rtment of H	lealth and <i>Death</i>		giene2 ( Reg. No.	004	06829
Physicia /Medic Examine	n al -	1. Decedent's Name (First, Middle, Last	rans Jr.	nenil	4b. City, Jown, o	r Location of Deal	2. Date of Dea Month	Day	Year 2004 ity of Death	3. Time of Death
Funeral Director		5. Social Security Number 6. San / a 15	7. Age (in yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birt	y Year) 2004	9. Birthp	place (State or Foreign
ith the Maryland or 28e-f show se notified at	Director	10a. State 10b. County  MD Howard		Town or Loc	ation			10g. Citizen o		0d. Inside City Limits 1 ☐ Yes 2√☐ No
	by Funeral Dir	10e. Street and Number  14007 Bramble Lane  11. Marital Status  1★Never Married 2□ Married	12. Was Decedent Ever in U.S Amed Forces? 1 ☐ Yes 2 X No If Yes, Give	1	2070		Specify Yes or No- to Rican, etc.)	US	A ace - Americ lack, White,	can Indian, etc.
within 72 hours ene. than "natural" is Medical Ex	Completed b	3 Widowed 4 Divorced  15. Decedent's Edit (Specify only highest grade)  Elementary/Secondary (0-12)	Year or Dates: ication le completed)  College (1-4or 5+)	(Give	ent's Usual Occup kind of work done OO NOT use retire n/a	during most of wo	orking	16b. Kind of		
is 1 and 2 should be filed within the filed within the filed with the filed within the filed with the filed with the filed in 27 is marked other than other treumatic avent, it as well as the filed with	To Be Co	17. Father's Name (First, Middle, Last)  Curtis Evans, Sr.  19a. Informant's Name/Relationship (7)		19h Mailin		Quantan	me (First, Middle, lease Fra	nklin		(Code)
Pages 1 and 2 si nent of Health an ent: If item 27 is rry or other treur		Quantanease Evans 20a. Method of Disposition 14 Burial 2 Cremation 3	/ Mother 20b. Pla	1400 ace of Dispos metery, crem	•	e Lane #	201, Lau Date /2004		arylar n - City or To	nd 20708 own, State
permit. Pages Department of Importent: If i eny injury or one		* 4 □Donation 5 □ Other (Specify,  21. Signature of Funeral Service Licens  **Public True**  **Public True*	xut M01338	7	. Name and Addre	ess of Facility F	leck Fun Road, L	eral Ho aurel,	ome, I	Inc. Land 20707
Physician and physician and physician and physician and the prinal-transit	dicai Examiner	23a. Part1. Enter the disease, or comp shock, or heart filter. List only of mediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque	ence of):	matu ruptu	rity re of n	nem brz	unas	,	Approximate Interval Between Onset and Death
The Cordins, F.O. BOX of the law requires that the death certific. The law requires that the death certific are has been signed by the attending plage 2 should be detached for use as a page 2.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3	Ectopic pregnanc Other (specify)	у			Date of delive Month	ery Day Year
w requires that to be signed by should be detail	۵	Part II. Other significant conditions co	ntributing to death but not resul	ting in the ur	nderlying cause gr	ven in Part I.	23e. Did to	v		he cause of death?
al neccinity of the law relicate has be	Completed						1 ☐ Yes	rmed? 2 No	death?	psy findings available mpletion of cause of
To the Hospital or Attending Physicien: The law within 24 buours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	(Month, Day Year)	R/Outpatien 28b. Time of Injury	28c. Inju	ner: 4 \(\sum \) Nursing	Home 5 Resident Resid	dence 6 □0		y)
UIVISION ital or Attending urs after death. ral Director: After lled in by the fune	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify)				City or Tou	m, State)	· · · · · · · · · · · · · · · · · · ·	al Route Number,
To the Hosp within 24 hos To the Fune completely fi	Medicai	29a. Certifier (Check only one)  29b. Signature and title of certifier	vsician: To the best of my know iner: On the basis of examination and manner stated.	on and/or inv	restigation, in my	opinion, death occ	urred at the time,	date and place	e, and due to	o the cause(s)
`\		30. Name and address of person who of	value,	23a) (Type,	Print)	41599	Prust	MIQI	: 21.	2004 2 MD
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	UT)	North	MN///	IMMYI	CUIM	11016	C) 1110

State of Maryland / Department of Health and Mental Hygiene 10 1 06830 State
Registrar AMFND ITFM #4a PER PHY G829 3/24/04 Centificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4:40a John Benson Edwards February 29, 2004 Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner <del>ad</del>t Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea April 26, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1⊠M 2□F Days Hours Min. Yrs. Missouri 508-10-7130 Director 92 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'naturel', or items 23a or 28a-f ehow other traumatic event, the Medical Exeminer must be notified at 1 Yes 2 No Director |Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Vashi Lane 20852 United States death 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after Hygiene. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Broadcast Journalist News Reporting Pages 1 and 2 should be fited vent of Health and Mental Hygie int: If item 27 is marked other t 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Benson Edwards, Sr. Sophia Burnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Imogene U. Edwards/ Wife 3 Vashi Lane, Rockville, Maryland 20852 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 KI Cremation 3 ☐ Removal from State March permit, Page Department of Important: If ony injury or rium, Inc. 3, 2004 Bethesda, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ \* 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 21. Signature of Fyneral S re Licensee Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M00689 23a. Part 1 Amer he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sensis Physician Unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Tract infection 15inary UNKNOW-Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical as the t IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy lor L in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy 1 ☐ Yes 2 🖫 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 12 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 2 ER/Outpatient 3□ DOA ihis funeral c 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending I 24 hours after death. Funeral Diractor: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide vitin 24 hours.
To the Funeral Di 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) March 1, istu da D0059871 2004 e MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cristin Parker Howe mo 9901 Medical Center Dr. ve Rockville, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 5 2004

	1 - State Unpend Item#23a Registrar		2,000	rtificate of				
ın	Decedent's Name (First, Middle, La					2. Date of Dea Month March	01 <sup>0ay</sup> 2004 <sup>ear</sup>	3. Time of Death 2005P
al -	Kenneth  4a. Facility Name (If not institution, gin	Freeman		4b. City. Town, o	r Location of Death		4c. County of Dea	th
er	1508 Saint Chris	stopher Court		Edgewoo	od		Harford	
	197-48-4565	Sex 7. Age (In yrs. I	ast birthday) 5 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day May 30	r, Year) Co	thplace (State or Foreign PA
	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limit
ō	Maryland Harfor	od		Edgew	ood			1 ☐ Yes 2 🛛 N
Directo	10e. Street and Number	<u> </u>	-	10f. Zip Code			10g. Citizen of What Co	ountry?
a D	1508 Saint Chris	tophers Court			21040			JSA
Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: B	Black
	15. Decedent's B	ducation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Business	/industry
plet	(Specify only highest gi	rade completed) College (1-4or 5+)	life.	DO NOT use retired	•			
Completed	Elementary/Secondary (0-12)	4 ( 45, 57,	Admi	nistrativ	ve Special	ist	U.S. Arm	у
Be (	17. Father's Name (First, Middle, Las				18. Mother's Name	(First, Middle,	Maiden Sumame)	
ြ	Unkno				Marilyn		eeman	
	19a. Informant's Name/Relationship	(Type, Print)					r, City or Town, State,	
	Cheryl Freeman  20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of	Maranto		hia PA 1	
	1 XBurial 2 ☐ Cremation 3	Removal from State . C	emetery, crei	matory or other plac	20/		Collingdale	
	* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service/Liv			Cemetery 2. Name and Addre				
	Misch	Hallens				n III BJC bezed	gs Funeral ena. MD 211	Home, P.A
	23a. Parr1. Enter the disease, or con	prolications that caused the deal					,	Approximate Interval Between
	shdck, or heart failure. List off Immediate Cause (Final disease or condition	Diabetic Ketoac	idosis					Onset and Death
	resulting in death)	Due to (or as a conseq						
	Sequentially list conditions.	b						
Examiner	Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury	Due to (or as a consequent	uence of):					
Kam	that initiated events resulting in death) Last	c Due to (or as a conseq.	neuce of).					
edical		0			-			
Z/MC	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Testania arr			23d. Date of de	,
icla	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d		□Ectopic pregnancy □ Other (specify) _	· · · · · · · · · · · · · · · · · · ·		Month	Day Year
Physician/M	9 🗆 Unknown	9□ Unknown						
by P	Part II. Other significant conditions	contributing to death but not res	ulting in the u	inderlying cause giv	ren in Part I.		obacco use contribute to	J
Ω			-			-		robably 4 RUnknor
ted b						24a. Was autop	an 24b. Were a prior to	utopsy findings availal completion of cause of
npleted b							rmed? death? 2□No 1 X Yes	s 2 No
Completed b				Ott	26. Place of Death			(scene
Be Completed	25. Was case referred to medical examiner?	Hospital:			4   Nuising Hon		dence & Other (Spe	ecify) (SCELLE
To Be Completed	examiner? 1 🙀 Yes 2 🗌 No		ER/Outpatie	of 128c Iniii			, , , , , , , , , , , , , , , , , , , ,	
To Be Completed	examiner? 1 🙀 Yes 2 🗌 No	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	rk?			
To Be Completed	examiner? 1 🙀 Yes 2 🗌 No	28a. Date of Injury (Month, Day Year)  28b. Place of Injury - At he	28b. Time of Injury	M 1	rk? Yes 2 □ No		Street and Number or R	ural Route Number,
To Be Completed	examiner? 1 🙀 Yes 2 🗌 No	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1	rk? Yes 2 □ No	28f. Location (S City or Tow		tural Route Number,
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edical Certification: To Be Completed	examinar?  1  Yes 2  No  27. Manner of Death  1  Natural 5  Pending investigation investigation determine  2  Accident 6  Could not determine  29a. Certifier (Check only one)  29b. Signature and title of certifier	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specif.  Physician: To the best of my kno aminer: On the basis of examina	28b. Time of Injury ome, farm, st	M 1 [] ireet, factory, office	rk? Yes 2 \( \sum \text{No} \)  me, date and place, a ppinion, death occurre	City or Tow and due to the a ad at the time,	vn, State) cause(s) and manner a date and place, and du	s stated. e to the cause(s)  th, Day, Year)

State

31. Date filed (Month, Day, Year) 32. Registrar's Signature

MAR 0 5 2004

Sports

Registrar

	an	1.	ford For Unpend Item { Registrar Decedent's Name (First, Middle, Las	t)				2. Date of Deat Month	th Day	3. Time of I
/Medi	cal	40	Lisa Marie I	Fulford		4b City Town, o	or Location of Deal	Februar	<del>-</del>	2004   622 ty of Death
Exami	ner	va.	8826 Yellow Spr			Frede			Fred	lerick
Funeral Director			210-96-2733	ox ☐ M 2∑F 7. Age (In )	yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1967	9. Birthplace (State or Country) Wash., DC
r 28a-f ehow notified at	tor	-	ual Residence of Decedent a. State 10b. County  MD Frede		City, Town or Lo					10d. Inside Cit
or 28a e notii	Director	1	e. Street and Number			10f. Zip Code		1		What Country?
23a	la [	-	8826 Yellow Sprin			2170		2		d States
al, or Iteme 23s Examiner must	by Funeral	11	Marital Status  TXXNever Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Tyes 2000 of If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub  1 ☐ Yes ※XXNo	oan, Mexican, Puer	to Rican, etc.)		ack, White, etc.
natural',	ed b		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of E	Business/Industry
	Completed		(Specify only highest grade) Elementary/Secondary (0-12) 12	College (1-4or 5+)	life.	kind of work done DO NOT use retire aitress	during most of wo	orking	Res	taurant
= 0 5	To Be C	17	Father's Name (First, Middle, Last) Jon Wikander Ful	ford				me (First, Middle, I ne Baird		
and h	J S		ea. Informant's Name/Relationship (7	• • • • • • • • • • • • • • • • • • • •				ural Route Number		
m 27		_	Carla O'Hagan/Si		8826 Ob. Place of Dispo	- The Party of the	Springs F	Road, Free		MD 21702
Department of Health and Mental Important: If item 27 is marked eny injury or other traumatic evonce.			a. Method of Disposition  1 ☐ Burial 2 ☐ Oremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crei Baltimor	matory or other pla e Cremato	orv at LE	3/2/04	Balt	imore, MD
Departiment injury inju	L	2	Signature of Finarel Service cer	seed // // /	2	Name and Address Timple Ti	ess of Facility Fibute Fu	neral and	d Crema	ation Center MD 20852
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/Medical xaminer	al Examiner	C th	equentially list conditions, any, bading to immediate susse. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last	b. Due to (or as a cor  Due to (or as a cor	ns⊯juence of]:					
ician	O			. d	regnancy					Date of delivery
nding physician use as the burial	n/Med		FEMALE: 3b. Was decedent pregnant	23c. If yes, outcome of pr		Textonio prognano	y		М	Aonth Day Y
by the attending physiciar ached for use as the buri	hysiclan/Med			23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify) _				
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To the morphism of Attended in the fact of the same equities that the death definition of the within 2 to the Funeral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burit	Be Completed by	P:	3b. Was decedent pregnant in the past 12 months?  1	Hospital:  2 a. Date of Injury  2 building, etc. (S	Petal death 3 [ 5 [ 5 ] 5 [ 5	ont 3 DOA  of 28c. Inju  A M 1 Creet, factory, office	26. Place of Oe ther: 4 Nursing try at ork? Yes 2 X No	24a. Was a autops of the following seath (Check only or Home 5 Residuated Res	es 2 No  un 24b  when 22 No  ence 6 XO  ow injury occu  treet and 88  cderick  ause(s) and m	3 Probably 4 U  D. Were autopsy findings a prior to completion of ca death?  1 Eyes 2 No  where (Specify) at Surred  2 Or Fuel Process  annual as stated.

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 0 0 4 06833 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH 7.00 P M **Physician** 2004 Barbara E. Ferguson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GLEN BURNIE ANNE ARUN DE NORTH ARUNDEL HOCPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 M 2 F Director 11/24/1912 216-76-1849 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo MD Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 9267 Fort Smallwood Rd. 21122 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Completed by White 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Steel Drum Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 10 Bookkeeper Reconditioning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland . Pages 1 and 2 should be filt tment of Health and Mental H tant: If item 27 is marked oth jury or other traumatic even Be Harry O. Buck Mary Radke 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Ferguson/Daughter 9267 Ft.Smallwood Rd., Pasadena, MD 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of H Important: If ite any injury or of 1 ■ Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk 03/06/04 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 169 Riviera Dr., Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IULMONARY **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dula to (or as a consequence of) Examiner and I-transit that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) detached Ö 9 Unknown 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Š 1 Yes 2 No 3 Probably 4 dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 **₩**No 1 ☐ Yes 2 No Vital director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 Division of 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funerel Director: After the completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Attending 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature un title of rentifier 29c. License number 29d. Date signed (Month, Dev. Year) MU 2004 30 Name and address of person who completed cause of death (Item 23a) (Type Print) 2061 ETWARADO Hospital 32. Registra 's Signature, 31. Date filed (Month, Day, Year) State sacks Registrar MAR 0 5 2004

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Alexander Felton ? 230A M athanie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospice Baltimore St. Michaels Villa If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Days Hours Min MD 212282810 1/12 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a State ral', or items 23a or 28e-f ehow Examiner well be notified at 1 Pres 2 No Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Street 1502 21217 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Pres 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other treumatic event, the Medical Expension 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Technician Medical 12th 2yrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sr Felton Jeannette Alexander ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rogers Avenue Baltimore MD 21207 36009 N. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 8 Owinas Wills 04 amison 4 □ Donation 5 □ Other (Specify) C Greene Funeral Service 21. Signature of Fun (rai) Service License 22. Name and Address of Facility aughn 5151 Baltimore National Pike Baltimore MD21221 au Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequen been signed by the attending physician a should be detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 🗀 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? page 2 2 No 1 Yes 2. No within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 2. No 1 Tyes 1 🗀 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Luce we 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VELL BA MD 13. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 5 2004 Registra

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_		Physic /Medi		James Graves				Month 1	Day 16	Year 04	11 · 0 · M
		Exami	ner	4a. Fecility Name (If not institution, give street and number)			or Location of Death		4c. C	ounty of Death	00 p.1
		Funeral		St. Agnes Hospital  5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birt	Balti hdev) If Under 1 Year	T 1 44 T 201 A	8. Date of Bir	th	NA 9 Birtho	ece (Stete or Foreign
	в	Director		219-40-5584 <sup>1</sup> X <sup>M 2□F</sup> 5		rs. Months Days		(Month, De	y, Year)	Coun	try)
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		or 28	Direc	10e. Street and Number		10f. Zip Code			10g. Citize	n of What Coun	- 21
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	pu	al Hyg	BeC	17. Father's Name (First, Middle, Last)	Ма	ntenance	18. Mother's Name (	First, Middle,		Parts mame)	•
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	Mai	2 2 2 3		19a. Informant's Name/Relationship (Type, Print)  Ms. Janis Greene (Siste	-	Mailing Address (Street					Code)
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	Baltimore,	permit. Peges Department of Important: If Ite eny injury or of		21. Signature of Funeral Service Ligensee	2	22. Name and Addre	ess of Facility		Russ	s F/H	рλ
	- risk			23a. Part / Inter the disease, or complications that caused	the death. Do n		V. North				Approximate
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			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F ertificate of	lealth and Death	Mental Hyg	iene2001	06836
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Yea	3. Time of Death
	Physicia /Medic		Elaine Davis	Golden				March 1	2004	11:12 P M
	Examin		4a. Facility Name (If not institution, give str				r Location of Deat	h	4c. County of De	
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-	Director		262-24-9888 Usual Residence of Decedent		84 Yrs.			NOV.20	1919 Pu	erto Rico
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nd 2 sh	aith and		19a. Informant's Name/Relationship (Type Kathleen Nadeau – d						City or Town, State g, MD 209	
ages 1	Department of Health and Mental Hygiene. Important: If item 27s or 28e-f show Important: If item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumatic event, If a Medical Exacilier mat be notified at once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	moval from State	-	matory or other pla			20c.Location - City o Baltimore	
<u>i</u>	artme ortan injur		21. Signature of Funeral Service Licenses		1		- 1			al Home, Inc.
2 8	Depa Impo		Deollo	Det C		11800 New	Hampshir	e Av., S	ilver Spr	ing, MD 20904
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Hospita	within 24 hours afte To the Funeral Dis completely filled in	edicai (	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Exemine	cian: To the best of er: On the basis of and manner state	examination and/or i	th occurred at the tinvestigation, in my	me, date and place ppinion, death occu	and due to the ca arred at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
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	4		30. Name and address of person who com Chukwuemeka Nwo				lin Drive		MD 20832	
_sk	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	's Signature			o, orney,	- LUUJA	
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DHMH 17 Rev 1/2001

ORIGINAL

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Funeral Director			Sex 1□M XXF 8	e (In yrs. last birthd 7 Yrs	Months Davs	If Under 24 Hrs Hours Min		1916	9. Birthpla Counti MAR	Ace (State or Forei
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e or 28s	Direc	10e. Street and Number 8422 TALLY H	O COURT		10f. Zip Code	093		10g. Citizen o	of What Count	ry?
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jiene. r than "nature the Madical E	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12 YEARS	ducation rade completed) College (1-4or 5	(G	ecedent's Usual Occupa Give kind of work done of fe. DO NOT use retired, SECRETA	during most of wo	orking		Business/Indi	
and Mental Hygiene is marked other than aumatic avent, Ita M	To Be C	17. Father's Name (First, Middle, Las: HARRY GILL	t)		failing Address (Street a	ELIZ		CAIN		
Deportment of Health and Mental Hygene. Important: If item 27 is marked other than "natur any injury or other traumatic avent, Its Maulcal once.		MARJORIE G. ROCK  20a. Method of Disposition  **MRUTH Community Co	□Removal from State	20b. Place of Di cemetery,	22 TALLY HO isposition (Name of crematory or other place Y VALLEY M. 22. Name and Addres RUCK TOWSO	G. 02-0	Date 04-2004	20c. Location	n - City or Tov UM, MAR	vn, State YLAND K ROAD
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After this certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the buriat-transit and inneral director.	Certification; To Be Completed by Physiclan/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1   Yes   2   INO   9   Unknown  Part II. Other significant conditions  FIGURE 1   VE NEW    25. Was case referred to medical examiner? 1   X Yes   2   No   27. Many r of Death   1   X Yes   2   No   28. Cacident   3   Suicide   6   Could not determine   29a. Certifier   1   Certifying F	Due to (or as b. Due to (or as c. Due to (or as d. Due to	a consequence of)  a consequence of)  a consequence of)  of pregnancy 2   Fetal death t time of death  out not resulting in th  MA  out not resulting in th  Outpury  28b. Tin Inju  4ury At home, farm to. (Specify)  outpury  to fmy knowledge, outpury  to fmy	atient 3 DOA Other of 28c. Injury Mornor Mornor Mornor Street, factory, office	en in Part I.  26. Place of Doer: 4 Unursing yat k? Yes 2 No	23e. Did to 1 24a. Was autoperformed to the control of the control	obacco use cover 2 No an 24 observed 2 No one) dence 6 Money occ fell Street and Nu will state Ass cause(s) and	Date of deliver Month	Day Year  e cause of death  ably 4   Unknown  by findings availanpletion of cause 2   No  Route Number,  iving  in MD  ated.
tall of the fundral o	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1   Yes   2   INO   9   Unknown  Part II. Other significant conditions  FIGURE 1   VE NEW    25. Was case referred to medical examiner? 1   X Yes   2   No   27. Many r of Death   1   X Yes   2   No   28. Cacident   3   Suicide   6   Could not determine   29a. Certifier   1   Certifying F	Due to (or as b. Due to (or as c. Due to (or as d. Due to	a consequence of)  a consequence of)  a consequence of)  of pregnancy 2	atient 3 DOA Other of 28c. Injurum, street, factory, office death occurred at the timor investigation, in my of 29c. Licens	en in Part I.  26. Place of Dier: 4  Nursing y at k? Yes 2 No me, date and pla ppinion, death occ is number	23e. Did to 1 24a. Was autoperformed to the control of the control	obacco use covered by the state of the state	Date of deliver Month  Date of deliver Month  Date of deliver Month  Date of deliver of Probability  Date of deliver of Date o	Onset and Death  Ty Day Year  e cause of death  ably 4 Unknown  sy findings availa  npletion of cause  2 Uno  Route Number,  iving  ated. the cause(s)  Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 5:02 Carolyn Elaine Gussio February 29,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 8. Date of Birth (Month, Day, Year)
Jan. 17, 1946

9. Birthplace (State or Foreign Pennsylvania **Funeral** 1 □ M 2 🖾 F Months Days Yrs. 58 217-42-3218 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23s or 28s-f show the Nedical Examiner must be notified at 10d. Inside City Limits Director Maryland 1 X Yes 2 □ No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1386 Rollinghouse Drive 21703 United States 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 Yes 2K No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Certified Nurses Aide 11 Private Nursing othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ith and Mental h Charles H. Lloyd Catharine Rafferty 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is ury or other trai Arnold J. Gussio, Jr./Husband 1386 Rollinghouse Drive, Frederick, Maryland 21703 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State March 4. permit. Pag Deportment Important: P any injury o \* 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland Cemetery 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, In
300 West Montgomery Ave., Rockville, MD 20850-2805 21. Signatur of Funeral Service Litenses or M0019823a. Part1. Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 00-011 03 /Medical Due to (or as a consequence of): **Examiner** mon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) rsicien and e burial-transit Due to (or as a consequence of) Completed by Physician/Medical physi the b attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 4 Junknown - ( - 0 - 9 - 7 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 2 No Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient ☐ ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 1) Natural Injury 5 Pending within 24 hours after death. To tha Funaral Diractor: A 1 ☐ Yes 2 ☐ No Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) el cy 1146 26 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Fredrack / ( 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert Earl Grafton na /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 201 HEA 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 21 7. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) **Funeral** - 1930 Days Hours Min 1⊠M 2□F 213-30-4149 73 Maryland Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Harford 1 ☐ Yes 2 ☑ No Completed by Funeral Director Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 503 Churchville Road 21014 USA or Itams 23a 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: White 3 Widowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) permil. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any righty or other traumatic event, tha Means. State Highway Elementary/Secondary (0-12) College (1-4or 5+) 6 Shop-Maintenance Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellwood Grafton E. Bettie Ennis Toliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Grafton/Son 503 Churchville Road, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens 3-4-2004 Bel Air, MD 21014 22. Name and Address of Facility
McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** DISTASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physicien and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown cate has been signed by page 2 should be detact that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? Yes 212 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funaral Director; 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 30. Name and address of erson who com, leted cause of death (Item 23a) (Type, Print)  $\mathcal{L}$ Hasw North Avenue 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 101

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21215-0020	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 ☐ Never Marri 3 ☑ Widowed	ied 2□ Married 4□ Divorced	1 ☐ Yes 2 If Yes, Give Yeer or Dat	. ⊠ No		1□ Yes			,		Specify		hite	
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7	State	е	31. Date filed (Mon	ARY (Bar) 20	10A 32. 16g	istrar's Signa	ature									

State of Maryland / Department of Health and Mental Hygiene 2004 06841 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** avid Charles 2:59 AW Ebruar 2004 29 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner VA MedICAL BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours -52-923 11XM 2□ F MARYL Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Meryland nent of Health and Mental Hygiene. Interest if Item 27 is marked other than "natural", or items 23s or 28e-f show any or other traumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND Funeral Director ANNE ARUNDE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number KOAD OUNTAIN 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Nes 2 No If Yes, Give Year or Dates: VIETNAM 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 □ Yes 2)⊠ No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ONSTRUCTION 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EVELYN HARLES HOFFMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) HARLES 29 MOUNTAIN ROAD, PASADENA MD 21122 TOPFMAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State LE VETERANS 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of important: If any injury or ROWNSVILLE ROWNSVILLE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
PEACEFUL ALTERNATIVE 2325 YORK RD MUIYOMIT 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Nalignant Mesothelioma Examiner Due to for as a consequence of Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): end Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 X Yes 2 🗆 No 1 ☐ Yes 2 전 No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: edical Certification: To 1 ☐ Yes 2 No 1 🗷 Inpatient 2 ER/Outpatient 3 DOA nours efter death.

ners! Director: After this y filled in by the funerel di 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RABERA MI) DUA ) AN 5 2004 3 Registrar's Signature State front Registrar

DHMH 16 Ray 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06842 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** MARCH NORMAN 02. 9:00 A. BLAINE HILL 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Ther)

Third FOREST HILL

To Age (In yrs. last birthday)

Months Days Hours Min.

Month, Day, Year)

Apr. 20, 1926 Examiner HARFORD MARINER HEALTH OF FOREST HILL 9. Birthplace (State or Foreign Country) MaryLand 5. Social Security Number 6. Sex **Funeral** 1X M 2□ F 217-22-7326 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23s or 28s-f show the Medical Examiner qualities inclified at 1 ☐ Yes 2€ No Maryland Monkton Harford Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21111 USA 3021 Jarrettsville Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced ed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Complet al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe eny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frances (NMN) Walton Floyd (NMN) Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3021 Jarrettsville Pike, Monkton, MD 21111 19a, Informant's Name/Relationship (Type, Print) Annie F. Hill/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Bel Air Mem. Gardens 3-6-2004 Bel Air, MD 1 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee teller U there 50 W. Broadway, Bel Air, MD 23a. Part1. Enter the disease, or complications that caused the safe. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Wer l neymon, a /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 4∏Pregnant at time of death 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown sate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 1 🗌 Yes 2 100 To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examination The pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and majner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titler of certifier 0 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Peter LoPresti Kusuce E 50 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 0 5

DHMH 17 Rev 1/2001

Registrar

MAR

State of Maryland / Department of Health and Mental Hygiene For State Registra 06843 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Catherine B. Hendley March 1, 2004 1:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rockville Nursing Center Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) | Min. | March 31, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 210 F Months 122-32-0486 87 Director 1916 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ?? Is marked other than "natural", or Itama 23a or 28a-f show traumatic event, the Modical Examinar must be notified at Montgomery Village Maryland Montgomery 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with I nd Mental Hygiene. marked other than "natural", or Itama 23a or? 2 Meadowcroft Court 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: à Specify: White 3 ☑ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be iment of Health and Mental I tent: If Item 27 is marked or Albert E. Brown Katherine Phant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra H. Kavanagh/Daughter 2 Meadowcroft Court, Montgomery Village, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition March 4, 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State ö permit. Pag Department Important: fi eny injury o \*4 ☐ Donation 5 ☐ Other (Specify) 2004 Bethesda, Maryland Pumphrey Funeral Nome/ Crematorium, Inc. 21. Signature of Funeral Service 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West Mont omery Avenue, Rockville, Maryland 20850-2805 M00689 Enter the disease, or complications that the disease, or complications that the disease on each line Part 1 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** <u>Hypertensive</u> Heart Disease /Medical resulting in death) Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine death certificate be executed Coronary Artery Disease and resulting in death) Last physicien and the purial-tr Due to (or as a consequence of): Physician/Medical as t attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death Dav 5 Other (specify) ☐ Yes 2 No the a detached 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Atrial Fibrillation s been si Completed 1 Yes 2 No 3 Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe certificate 21 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2K No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 ⊠Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident the Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide hours after 0 the Hospital within 24 hours of To the Funeral filled 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D47330 March 2, 2004 V JOSENIA yours 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 West Edmonston Drive, #207, Rockville, MD 20852 Thomas V. Joseph, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 5 2004 boarker

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Division of Vital Records,

			1 - For State Ragistrar	State of Marylan	d / Departme	ent of Health and I	Mental Hygie	ene 2004	06841
· .	Physicia		Decedent's Name (First, Middle, La     WALTER HAR				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, giv	e street and number)		ty, Town, or Location of Deat		12,2004 4c. County of Deeth	4:25AM
	Funeral Director		GILCHRIST CENTE  5. Social Security Number  245 18-1956  Usual Residence of Decedent			TOWSON  der 1 Year   If Under 24 Hrs is   Days   Hours   Min.	8. Date of Birth (Month, Day, Y		ORE place (State or Foreign try) CAROLINA
board with the Maryland	ufied at	ctor	10a. State 10b. County  MD • N/A		y, Town or Location	E		1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
with th	3a or 28 Il be no	i Dire	10e. Street and Number 1833 E. LAFAYET	TE AVENUE	10f. i	Zip Code 21213	10g	. Citizen of What Cour	itry?
1 Z 1 3-0030		by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? ↓ JYes 2 □ No #Yes, Give Year or Dates:		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puen 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: BLK	etc.
	"natural", fedical Exa	Completed	15. Decedent's E (Specify only highest gra	ide completed)	16a. Decedent's U (Give kind of life. DO NOT	work done during most of wor	rking 16	b. Kind of Business/Inc	
	al Hygiene. other then 'vent, Iza Me	Be Comp	Elementary/Secondary (0-12)  8TH  17. Father's Name (First, Middle, Last	College (1-4or 5+)	LABOR		B me (First, Middle, Ma	& O RAII	ROAD
yidh	2 2 0	To B	JOHN HARRIS		1	LENA	JOHNSON		
e, Mai	ulth ar 27 Is r trau		19a. Informant's Name/Relationship ( ALICE MONROE  20a. Method of Disposition	(DAUGHTER)		oss (Street and Number or Ru DUISE AVENUE Name of	E BALTIMO		1214
Saltimor	2= 5		1 Denation 2 □ Cremation 3 □ '4 ☑ Denation 5 □ Other (Special	Removal from State CED	emetery, crematory of AR HILL	r other place) CEMETERY MA	AR.8,2004	ANNE ARUN MARVIA	DEL CO,
Dall	Departmen Importent any injury once.		21 Signature of Funeral Service Lice	D. Scruss	CALVI	and Address of Facility N.B. SCRUGO E. PRESTON	STREET	L HOME	
	hysician /Medical		23a. Part1. Enter the disease, or com shock, or heart faifure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line.  a	Stage	reur di	or respiratory arrest		Approximate Interval Between Onset and Death
7 3	xaminer	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	uence of):				
John John	S S	Icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequent	uence of):				
O. BOX 58	the attending phone of the check of the attending phone of the check o	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3 Ectopic			23d. Date of delive Month	ery Day Year
cords, P.O	been signed by the atte should be detached for	þ	Part If. Other significant conditions	contributing to death but not resu	P	~	23e. Did tobac	cco use contribute to the	
I Mec	ate has	Completed	multiple Dealete m	ollitus		····	24a. Was an autopsy performe	prior to cor death?	psy findings available impletion of cause of
or vital	is certific director,	o Be (	25. Was case referred to medical examiner?	Hospital:	5D/0	Other	ath (Check only one)	4	.11
_ 9	n 0 0	<b>!</b>	27. Manner of Death  1 Avatural 5 Pending 2 Accident investigation	28a. Date of fnjury (Month, Day Yeer)	ER/Outpatient 3 D 28b. Time of Injury M	28c. Injury at Work?  1 Yes 2 No	fome 5 Residence 28d. Describe how	Carrie (apren)	Hogica
UIVISION	n Topping of American n 24 hours after death.	Certification:	3 Suicide 6 Could not be determined		ome, farm, street, fact	ory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
2	within 24 hours after To the Funerel Dir completely filled in	Medical (	29a. Certifier Certifying Pl (Check only one) 2 Medicat Exe	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigati	ed at the time, date and place on, in my opinion, death occu	e, and due to the caus urred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
-	within 2 To the	Me	29b. Signature and title of certifier	They Ril		29c. License number	29d	Date signed (Month, 2)	Day, Year)
4	H1		30. Name and address of person who	completed cause of death (Item	6 70 1	D25205	St. X	Salto, n	nd 2120x
į.	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa	tue Soon	61			

State of Maryland / Department of Health and Mental Hygiene 2004 06845 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2nd 2004 9-25 AM **Physician** MARCH 220 ANNA /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SAMARITAN BALTIMO HOSP ITAL (100 D) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☐ F 215-12-1027 81 Maryland Director Usual Residence of Decedent the Maryland 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State items 23a or 28a-f show the Medical Exercitive must be notified at 1 Yes 2 No Director MD Baltimore Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 3201 Putty Hill Avenue U.S.A. Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 6 1 Yes 2 No Specify: White Maryland 21215-0036 Specify: 3 

Widowed 4 □ Divorced Year or Dates: "natural", 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If itam 27 Is marked other than ' ury or other traumatic event, Its Ma College (1-4or 5+) Tailor Oakloom 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony Palmisano Josephine CoCo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3201 Putty Hill Avenue Baltimore, Maryland 21234 Marie J. Izzo- Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Important: If any injury or 3/5/04 Most Holy Redeemer Baltimore, Maryland Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Heather Cain 22. Name and Address of Facility 5305 Harford Road Baltimore, Maryland 21214 ather Ohen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of): **Examiner** DISEASE ARTERY CORONHAY Sequentially list curronions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-transif Due to (or as a consequence of) P.O. Box 68760. use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, been signe should be RENAL DISEASE 2 0 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 100 or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Ē 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending after death.
I Director: Af 1 🗌 Yes 2 🗌 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a 29a. Certifier 1 (Gordifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier M.D. aras D58120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCA RAVEN POLUD, BALT MD 21239 HOSPITAL SAMARITAN 32. Registrar's Signature State Registrar

	For State Registrar		Olate 0	f Marylan	Cei	rtificate of	Death	7		ygleri Reg. N		04	06846
		e (First, Middle, Last	1)						2. Date of D	eath			3. Time of Death
Physician	Gladys	V. Jenki	ns						Month Februa		ay 27, 2	Year	11:45 P M
/Medical - Examiner		If not institution, give		nber)		4b. City, Town,	or Location		r CDI da		c. County		111:45 P
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uneral	5. Social Security N	Number 6. Se	x	7. Age (In yrs.	last birthday)	If Under 1 Yea	r If Unde	r 24 Hrs.	8. Date of 8	irth		9. Birth	lace (State or Foreign
rector	213-56-0	422	⊐м <b>Ж</b> Х <b>ў</b> Г	83	Yrs.	Months Day:	Hours	Min.	(Month, I Sept.			Coui Mary	land
	Usual Residence of	f Decedent				<b>.</b>			P - P		720		
mportant: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Exam arcmust be notified at page.  To Be Completed by Funeral Director	10a. State	10b. County		10c. Cit	y, Town or Lo	ocation							0d. Inside City Limits
to	MD	Montgor	nerv	S	Silver	Spring							1 Yes 2 □ No
ied ied	10e. Street and Nur	mber				10f. Zip Code				10g. C	itizen of W	Vhat Cou	ntry?
E C	815 Hol:	lywood Ave	enue			2090	)4				USA	1	
Funeral Director	11. Marital Status		12. Was Dece	dent Ever in U.	.S. 13. 1	Was Decedent of If Yes, specify Cu	Hispanic O	rigin? (Sp	ecify Yes or N	lo-			can Indian,
2	1 Never Marri	ried 2 Married	1 Tyes	2 X No					nican, etc.)			k, White,	etc.
þ	3	4 Divorced	If Yes, Giv Year or D	ates:		1⊡Yes 21∏ N	o Specify	/:			Specify.	Whi	te
Completed	(Snev	15. Decedent's Edi	ucation		16a. Deced	dent's Usual Occi	upation	st of work	ina	16b.	Kind of Bu	siness/In	dustry
혈	Elementary/Seco		College (1	-4or 5+)	life.	DO NOT use retir	ed)	01 01 11011	<b>y</b>				
5	Źth		Ø		Home	maker					Own	Home	
Be (		(First, Middle, Last)					18. Moth	ner's Nam	e (First, Midd	le, Maide	n Sumam	Θ)	
2	Nathan V	Washingtor	n Merso	n			Lau	ra Sı	ısan Du	ıstir	ı		
	19a. Informant's N	lame/Relationship (T	ype, Print)		19b. Mailir	ng Address (Stree	et and Numb	ber or Rur	al Route Nurr	ber, City	or Town,	State, Zip	Code)
	Janet L.	Waters/Da	aughter		815 H	ollywood	d Aven	ue,	Silver	Spr	ing,	MD 2	0904
	20a. Method of Dis	*		1 -	Place of Dispo	osition (Name of matory or other p			Date	_	Location -		
		☐ Cremation 3 ☐ I		State	ion Ce		- 1	lar.	6, 200	4 B	urton	svil	le, MD
ai .		uneral Service Licens	-4/		22	2. Name and Add	ress of Faci	lity Don	aldson	Fun	eral	Home	, P.A.
Suce	► X 1/1/.	746/2 la 1	V/L	1400777	3	13 Talbo							
0.00	23a Part1 Enter1	the disease, or comp	lications that o	M00773		er the mode of th	ung such a	s cardiac	or respiratory	arrest			Approximate
-10	shock, or hea	art failure. List only o	one cause on e	ach line.			,	0 00.000					Interval Between Onset and Death
an	disease or condition resulting in death)	on	u			Disease	)						Years
cal ner	rosalling in dealin)		Due to	(or as a conseq	uence of):								
	Sequentially list co	onditions,	b										
ine	cause. Enter Under Cause (Disease or	erlying	Ulle to	or as a conseq	MANUS OUT								
Examiner	that initiated events resulting in death)	S	C. Due to		wonen of):							-	
	, ,		D09 (0	or as a conseq	dence of).								
dicai Examir			d	<del></del>									
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Σ	IÉ ÉÉMAI É												
an/M	IF FEMALE: 23b. Was deceden	nt pregnant		come of pregna		⊒Ectopic pregnan	cy				23d. Date		*
sician/M	23b. Was decedent in the past 12 1 \( \superscript{Yes} \) 2 §	nt pregnant 2 months?	1⊡Live t 4⊡Pregr	irth 2 ☐ Feta lant at time of d	aldeath 3 □	□Ectopic pregnan	cy				23d. Date Mor		ery Day Year
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neral director, page 2 should be detached on; To Be Completed by Physi	23b. Was deceden in the past 12 1	ificant conditions or heral Vaso  wred to medical  No  the could not be determined  1 Certifying Phy 2 Medical Exam  d title of certifier  dress of person who of	Hospital: 1 28a. Date (Mon	inth 2 Feta lant at time of down  eath but not res  i Sease  inpatient 2 for input, not find the research of t	DEP/Outpatier  28b. Time of Injury  ome, farm, str	other (specify)  Inderlying cause of the second of the sec	26. Place there 4 No	De of Deat	24a. We auding the second seco	yes: s an opsy formed? 2&\ \( \) \(	More ouse control of the second of the secon	nth  3 Prot  Vere autor  iror to coleath?  Yes  er (Specified)	Day Year  ne cause of death?  pably 4 Unknown  psy findings available mpletion of cause of 2 No  at Route Number,  tated.  o the cause(s)  Day, Year)
filled in by the funeral director.	23b. Was deceden in the past 12 1	ificant conditions con	Hospital: 1 28a. Date (Mon 28e. Place build ysician: To the liner: On the band man 2 completed cause 10313	inth 2 Feta lant at time of down  eath but not res  i Sease  inpatient 2 for input, not find the research of t	DER/Outpatier  28b. Time of Injury  ome, farm, str fy)  owledge, deatl ation and/or in	other (specify)  Inderlying cause of the second of the sec	26. Place there 4 No	De of Deat	24a. We auding the second seco	yes: s an opsy formed? 2&\ \( \) \(	More ouse control of the second of the secon	nth  3 Prot  Vere autor  iror to coleath?  Yes  er (Specified)	Day Year  ne cause of death?  pably 4 Unknown  psy findings available mpletion of cause of 2 No  at Route Number,  tated.  o the cause(s)  Day, Year)

			1 - For State Registrar	State of Maryland /	Cert	ificate of l	Death	Reg	200L	
2. Sec.	Physicia /Medic		1. Decedent's Name (First, Middle, Las Matthew J.	<sup>()</sup> Kanya				2. Date of Death Month February	Day Year 29, 2004	3. Time of Death
	Examin		4a. Facility Name (If not institution, give 6200 Tamara Court				Location of Death		4c. County of Dea	th
43	Funeral Director			9X 7. Age (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )		thplace (State or Foreign ountry)
	Maryland a-f ehow	ctor	Usual Residence of Decedent  10a. State MD 10b. County Pr	ince Georges	own or Loc	ation	Suitla	and		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 6200 Tamara Court			10f. Zip Code	0746	100	g. Citizen of What Co Unite	ountry? ed States
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Mcdical Examinal cautice multified at ODGe.	þ	11. Marital Status  1XXever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ★ 9 s 2 No If Yes, Give Year or Dates:		as Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Błack, Whi	
15-0	in 72 ho n "natur	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give k	ent's Usual Occup ind of work done of ONOT use retired	during most of work	king 16	6b. Kind of Business	/Industry
212	ygiene. yer the	Com	Elementary/Secondary (0·12)	College (1-4or 5+)		· · · · · · · · · · · · · · · · · · ·	Clerk			ernment
land	ld be fit ental H ked oth Ic even	To Be	17. Father's Name (First, Middle, Last) Matthew J. Kanya	a				e (First, Middle, Ma an Wilsor	,	
, Maryland 21215-0036	and 2 shou laith and M 1.27 is mar er traumst		19a. Informant's Name/Relationship (7 Matthew J. Kany	ya,Sr./ Father					City or Town, State, di Maryland	
Baltimore,	Pages 1 announce of He Bent: If item Bent: On other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State Our 1	tery, crema Lady of		m, March 5		Penndel, P	
Balt	permit. Departe Imports any inj		21. Signatule of Forecat Service Licon	victor P. Doda, G	a	marles L. :	Stevens Fur	eral Home, Baltimore		
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. CONTACT GUA	Oo not enter	r the mode of dyin	g, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death
San e	Examiner	Ja	Sequentially list conditions	b. Due to (or as a consequence)						
0	tificate be executed ig physician and as the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
68760,	cate be physicia the bu	edical		d.						
P.O. Box 6	The law requires that the death certif ste has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	ath 3⊟£	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
	w requires that to been signed by should be detail	þ	Part II. Other significant conditions of	ontributing to death but not resulting	g in the und	derlying cause giv	en in Part I.	23e. Did toba	~/	o the cause of death?
Vital Records,	The law recate has been page 2 sho	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	(Output:==1	3□ DOA Oth	O.E.	th (Check only one)	77.000	
Division of	fte fre	atlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28t	b. Time of Injury	28c. Injur	y at	ome 5 Residen 28d. Describe how	injury occurred	ELF
Divis	o Hospital or Attendi 1.24 hours after death. e Funeral Director: A letely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)	, farm, stre			City or Town.	et and Number or A State) PACT, SVI	Ural Route Number,
	Hospi 24 hou Funer etely fill	edical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowled niner: On the basis of examination and manner stated	dge, death and/or inve	occurred at the tinestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	se(s) and manner a e and place, and du	s stated. to the cause(s)
	To the I within 2: To the I complet	Me	29b. Signature and title of certifier			29c. Licens	e number	290	d. Date signed (Mon	h, Day, Year)
			- auess				.C.M.E.	N	March 01,	2004
	6		30. Name and address of person who				reet, Bal	timore, N	Maryland 2	21201
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature 5 2004	,	45				

			1 - For State Registrar	State of Maryland /		nent of H			jiene 1eg. No.	2004	06848
\$ 10 m	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Wanda  I.	Knasial	<			2. Date of Dea Month Febru	lary	28, 2a	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give st Stella Maris  5. Social Security Number 6. Sex				Location of Deat COIUM If Under 24 Hrs	_		Baltin	nore Co.
te .	Funeral Director			M 200 F 7. Age (In yrs. last I		nths Days	Hours Min.		Year)	3 ma	place (State or Foreign intry)
	e Marylan e-f show	ctor	Maryland Baltim	^	own or Location						10d. Inside City Limits 1 ☐ Yes 227No
	ath with the 23a or 28	rai Director	205 E. Joppa	Rd. Suite 2	008		286		L	ten of What Cou	A.
2-0036	ours after des ral', or Itama Examinar or	i by Funerai	11. Marital Status  1 Never Married 2 Married  Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1		Decedent of His, specify Cubar (es 2/10)No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		4. Race - Amer Black, White Specify:	
2121	be filed within 72 hours after death with the Maryland ital Hygiene.  ad other then "netural", or Itama 23a or 28a-f show event, the Mexical Examinar ment be notified at	Completed	15. Decedent's Educ. (Specify only highest grade Elementary/Secondary (0-12)		(Give kind life. 90 N	S Usual Occupa of work done d IQT use retired,	uring most of wo	rking		utzle	,
and	d la b	To Be (	17. Father's Name (First, Middle, Last)  IGNATIUS	Denko			18. Mother's Nat	me (First, Middle,	/ .	Sumame) Sowsk	la
, Mary	s 1 and 2 short Health and item 27 is mother traum		19a. In ormant's Name/Relationship (Typ. Mrs. Rose Beru	ibe (Daughter)	2056	E. Jop.	a Rd.			0	ip Code) 1, MO 21286
Baltimore,	Page ment o ant: If ury or		20a. Method of Disposition  **Burial 2 □ Cremation 3 □ Re  * 4 □ Donation 5 □ Other (Specify)	,ceme	of Disposition of Property, cremator	y or other place	n. Man	h 3,2004			Maryland
Ball	permit Pag Department Important: any in ury once.		21. Signature of Funeral Service License	Jan, s.	72. Na 23.			atives t		ral+Co	emation Ctr. 21093
	Physician /Medical		23a. ₹aft1 ent the wase, or complic shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	arons that caused the death. D cause on each line.  END STAKE DE  Due to (or as a consequence)	MENTIA	e mode of dying	g, such as cardia	c or respiratory ari	rest,		Approximate Interval Between Onset and Death
8760,	cate be executed hysicien and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence							
.O. Box 687	Physician: The law requires that the death certificate be executed tribic certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	ath 3□Ecto	opic pregnancy er (specify)			2	3d. Date of deliver Month	very Day Year
<u>α</u>	quires that t n signed by uld be deta	کر	Part II. Other significant conditions conf	tributing to death but not resulting	g in the underf	ying cause give	en in Part I.		_		the cause of death?
al Records,	Physician: The law require this certificate has been si al director, page 2 should b	Completed						24a. Was a autop perfor	sy med?	24b. Were aut prior to d death? 1 \( \text{Yes}	opsy findings available ompletion of cause of 2 No
of Vital	hysician this certif	To Be	T Yes 2 No	ospital: 1 Inpatient 2 ER/			or: 4 🗶 Nursing F	ath <i>(Check only of</i> Home 5☐ Resid	ence 6		ify)
Division (	Attending Fir death. actor: After by the funera	Certification:	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day Year)			at :? /es 2 □ No	28d. Describe h	ow injury	occurred	
Divi	To the Hospital or Attending I within 24 hours after death.  To the Funaral Diractor: After completely filled in by the funer		4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)				City or Tow	n, State)		ral Route Number,
	the Hosp nin 24 ho the Fune npletely f	ledical	(Check only 2 Medical Examin	ician: To the best of my knowled er: On the basis of examination and manner stated.	dge, death occ and/or investi	gation, in my op	pinion, death occi	urred at the time, o	date and	place, and due	to the cause(s)
	To To Con	Σ	29b. Signature and title of certifier	)-		29c. License	3721		29d. Date	3/2/	O C
	10		30. Name and address of person who cor  DR. TARIQ MAHMOOI				TIMONIUM	, MD 210	93	, , , ,	
a In	Sta Regist		31. Date file Dath Pay Year 104	32. Registrar's Signature							

DHMH 17 Rev 1/2001

FEBRUARY 28, 2004

State of Maryland / Department of Health and Mental Hygiene ? For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** RARS 400K /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GILCHRIS BALTIMORE LWOI If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 12KJM 2□ F 220-12-9898 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mentai Hygiene. Important: If item 27 is marked other than "natural; or thems 23a or 28a-f show any injury or other traumatic event. If a Marical Example or contact traumatic event, If a Marical Example or contact. 1 ☐ Yes 2 No Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9.2.C 91988 BRIDEZ Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

TX Yes 2 | No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 25 Married Maryland 21215-0036 1 ☐ Yes 201 No Specify: Specify: STIHW 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BITHLEHER 127RS-18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be KIRK. A-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BROBE ROLD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State E 1829 1 ☐ Burial 25 Cremation 3 ☐ Removal from State 4026 4 □ Donation 5 □ Other (Specify) FOREST 21. Son ure of Funeral Se vice Licensee 22. Name and Address of Facility 12000 1 (ARYLAN) 21234 ( Contraction 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10ars Physician /Medical Due to (dr as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) P.O. Box 68760 the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes Division of Vital Fo the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To tha Funaral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 17992 ,2004 uns (Item 23a) (Type, Print) 30. Name and address of person who completed cause of deads 2120% Charles 670 31. Date filed (MM) Pay 32 Registrar's Signature State Acres . Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 06850Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Harriet Addie Kennedy March 3, 2004 9:00 AM /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dealh Examiner 3025 Putty Hill Avenue Parkville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 24,1909 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2)(C)(F 220-74-6853 94 Director Vermont Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at Maryland Baltimore Parkville 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 3025 Putty Hill Avenue 21234 U.S.A. or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: White 3 ₩ Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 10 yr's other t 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any unity or other traumatic event page, 18. Mother's Name (First, Middle, Maiden Sumame) Sullivan Smith William Harriet Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Littlepage - Daughter P 0 Box 801 Reisterstown, MD 21136-0801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 □ Donation 5 XI Other (Specify) Entonoment Lorraine Park 3/6/2004 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 au Malloon. 23a. Part1. Enter the disease, or complications that deutsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years /Medical Due to (or as a consequence of) **Examiner** Congustine signar tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a consequence of): Examine to the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 D No
9 ☐ Unknown Month 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were aulopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🏋 No autopsy performed?

1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2 No 2 this 27. Manner of Death 1 Natural Certification; 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending death. 1 ☐ Yes 2 ☐ No i Director: 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 146082 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEETA DESHPANDE, M.D 9105 FRANKLIN SQUARE DRIVE 11. Date filed (Month, MARPOR) 5 2004 32. Redistrar's Signature , BALTIMORE 31. Date filed (Month Man Rea) 5 Registrar

Physiciar /Medica	_	Registrar		(	Cenn	ment of F	Jeath		R	eg. No. 👊	004	068	
	Maria M Krauco										Year 2004	3. Time of Death 10:55P.	
Examine		4a. Facility Name (If not institution, give Anne Arundel Medi	· ·			b. City, Town, or				4c. Coun	4c. County of Death		
Funeral Director		5. Social Security Number 6. Se		ge (In yrs. last birth	nday) If	nnapoli f Under 1 Year Nonths Days	If Under	Min.	Date of Birth (Month, Day, une 2,	Year)	Cou	place (State or Fore	
aryland ahow dat		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Locati	ion						I0d. Inside City Lim	
or 28e-f	Director	MD Anne Aru  10e. Street and Number	ndel	Lau		10f. Zip Code			1	0g. Citizen of	f What Cour	1 Tes 2	
er death v Items 23e	by Funeral	3304 Sudlersville  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	?	If Ye	20724 s Decedent of H es, specify Cuba Yes 2 X No	n, Mexican	i, Puerto Ric	ify Yes or No- lican, etc.) 14. Race - An Black, Wi Specify: 1			etc.	
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lid be filled lental Hygid ked other ic event, I	To Be C	17. Father's Name (First, Middle, Last) Theordore Albert			11011101	marc I			ne (First, Middle, Maiden Surname)  Kleebauer				
		19a. Informant's Name/Relationship (7) Donna Maria Dark		1		hevalie	and Numbe	er or Rural R	loute Number,	City or Town			
Dermit. Pages 1 and 2 Department of Health in mportant: If item 27 i any injury or other tre	Ī	20a. Method of Disposition  1 Durial 2 Cremation 3 1  1 Donation 5 Other (Specify,	Removal from State	20b. Place of L	Disposition, cremato	on (Name of ory or other places S Cemete	θ)	Date	9	20c. Location	- City or To	own, State  Marylan	
permit. Pages i Department of F Important: if ite any injury or ot once.	(	21. Signature of uneral Service Licens	rat me	013318	22. Na	ame and Addres	s of Facility	y Flec	ck Fune	ral Ho	ome, I	inc. and 20707	
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hysician this certifial director	lo Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No  27. Manger of Death	Hospital: 1 Impati			3 □ DOA Othe	er: 4□Nur	rsing Home	5 Resider	nce 6 Otl		")	
f or Attending Phater death.  Director: After this in by the funeral						M 1	Work? 1 □ Yes 2 □ No			eet and Num State)	ber or Rura	l Route Number,	
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To the 1 within 2 To the 1 To the 1 Complet	Me	29b. Signature and title of certifier  Alexandres and address of person who c	) D		Type Prin	29c. License	510		29	Od. Date signe			
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Fune	eral		5. Social Security Number	6. Sex		7. Age (In y	rs. last birthday,	If Unde	1 Year	If Under:		8. Date of Bir (Month, Da	th Vear			place (State or Foreign
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pur *		-	Usual Residence of Decedent  10a. State 10b. Coun	v		10c.	City, Town or L	ocation							1	Od. Inside City Limits
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36 safte	THE STATE OF THE S	by F.	1 Never Married 2 Ma 3 ☑ Widowed 4 □ Divorce		1 ☐ Yes If Yes, G Year or [	ve		1 🗆 Yes	2 <b>⊠</b> No	Specify:				Specify:		White
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or Fe, North of Health item 27	othe	-	20a. Method of Disposition				. Place of Disp cemetery, cre	osition (Na	me of			Date		ocation - C		
altimore, mit. Pages 1 ar partment of Hea	iry or		1 ☐ Burial 2 🖾 Cremation 1 ☐ Donation 5 ☐ Other		emoval from	State H	illtop :	Svc.	Corp	- 3	<u>-4-</u> [	)4	Тоы	son, I	Mary	land
Balt permit. Departr Import	any in	Ī	21. Signature of Financial Service	cerse		_										lome, Inc.
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		1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of F	lealth and Death			4 06853	
Physi /Med Exam	dical	Decedent's Name (First, Middle, La     Ngo Luong Le     4a. Facility Name (If not institution, give)			4b. City, Town, o	r Location of Dea	2. Date of Deat Month March	Day Year 3 200 4c. County of Dea	1	
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Physiciai /Medica		23a. Part1. Enter the disease, or com shock, by lear failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line.  Carcin  Due to (or as a consequ	oma Lu		g, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death	
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ng ng	ation: To B	examiner?  1 Yes 2 XNo  27. Manner of Death 1 XNatural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun Worl	<sup>er:</sup> 4 ☐ Nursing H		nce 6 Other (Spe	cify)	
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	sai Certification:	3 Suicide 6 Could not be determined	ysician: To the best of my know	viedge, death	occurred at the time	ne, date and place	City or Town	use(s) and manner as	hatets:	
To the He within 24 To the Fu	Medical	one) 2 Madical Exam	iner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my of	oinion, death occi	urred at the time, da	ed. Date signed (Monte) March 3,	h, Dey, Year)	
\		30. Name and address of person who P.S. Aujla, M.D	completed cause of death (Item 5632 Annar	23a)(Type.	Print) Road, Sui		Bladensbu	irg, MD 2	0710	
S Regis	itate strar	31. Date filed (Month, Day, Year) MAR 0 5 200	32/Registrar's Signat	ure M	poorks	/				

			1 - For State Registrar	State of M	laryland / De	epartme Certifica	ent of H	lealth a	and Menta	al Hygie	ene2004	06854
H	Physici		1. Decedent's Name (First, Middle, La .Mary Liesch	st)					M	ate of Death onth ruary	Day Year 22 2004	3. Time of Death  1:55 P
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number	)	4b. Ci	y, Town, o	r Location o		Luci	4c. County of Dea	
			Morningside Ass	isted Liv	ing	Lau	rel				Prince G	eorges
Ų:	Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs. last birtho	Month	der 1 Year s Days	If Under Hours	Min. (M	te of Birth onth, Day, Y	rear) C	thplace (State or Foreign ountry)
	Director		579-14-3705 Usual Residence of Decedent	_ W 231	81 Yr	s			Nov	7. 17,	1922 Mar	yland
	land w		10a. State 10b. County		10c. City, Town o	r Location						10d. Inside City Limits
	Mary -1 sh	ţ	Md Prince G	eorges	Laure1							1 Tx Yes 2 □ No
	r 28a	rec	10e. Street and Number			10f.	Zip Code			100	g. Citizen of What Co	ountry?
	th with	al D	7700 Cherry Lane			2	0707				U.S.A.	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland stal Hyglene. ed other than "natural", or flems 23a or 28a-f show event, the Medical Examinat must be incitiled at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Types 2 If Yes, Give Year or Dates:			edent of Hoecify Cuba		gin? (Specify Y n, Puerto Rican,	es or No- etc.)	14. Race - Ami Black, Whi Specify: Wh	
9	2 hor	Completed	15. Decedent's E	ducation	16a. D	ecedent's U	sual Occup	ation	t of working	16	6b. Kind of Business	
218	within 7 ene. than "r	nple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	fe. DO NO1	use retired	d)				
21	filed with Hygiene. other ther	Con		1+	Adı	ninist	rativ		istant		U.S. Gov	ernment
and	be fill Hall H	Be	17. Father's Name (First, Middle, Last,								aiden Sumame)	
ž	should be ind Mental marked o	မ	William H. Forre		19h A	Azilina Addre	ss (Street		le11 Pur		City or Town, State,	Zin Code)
<u>R</u>	id 2 should the and 27 is my traum		John F. Liesch S						nbelt,			zip Gode)
	s 1 and 2 should f Health and Mer flom 27 is marke other traumatic		20a. Method of Disposition		20b. Place of D		lame of	Ţ.	Date	_	oc. Location - City or	Town, State
Baltimore,	permit. Pages I Department of H Important: If Ite eny injury or ot once.		1 ➡ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif		MD. Vet	,			/04/200	4 C	heltenham	. Md
ij	mit. F partm portar injui		21. Signature of Funeral Service Licer								al Home,	
ä	Depariment of the part of the		Kenia de	Want M	01338						1, Md 207	
W3.			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death. Do not line.	enter the m	ode of dyin	g, such as	cardiac or resp	iratory arres	t,	Approximate Interval Between
X	Physician		Immediate Cause (Final disease or condition		Obstruct							Onset and Death  10 years
*	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of)	:		.uy				Jo y cars
		<u></u>	Sequentially list conditions,	b. Due to for a	s a consequence of)							
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	22012 (21 21		•						
,	execu n and ial-tra	Exal	that initiated events resulting in death) Last	c. Due to (or as	s a consequence of)	:				_		
8760,	ate be executed hysicien and he burial-transit	cal		_ d.								
9	tificat ng phy as th		IEEE.								1	
.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		e of pregnancy 2 □ Fetal death at time of death	3 Ectopic 5 Other		′			23d. Date of de Month	liv <b>ery</b> Day Year
Records, P.	quires that n signed b uld be deta	by	Part II. Other significant conditions of Cancer of the R	_	_	ne underlyini	g cause give	en in Part I.	. 23			o the cause of death?
00	aw requir s been si 2 should	Completed							24	ta. Was an		utopsy findings available
R	The lav	E O					···········		1[	autopsy performe □ Yes 2 5	od? death? StNo 1 ☐ Yes	completion of cause of
Vital		Bec	25. Was case referred to medical examiner?					26. Place	of Death (Ched		Α, ν	Assisted
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 承No	Hospital: 1 ☐ Inpat		atient 3		4 🗆 Nu	rsing Home 5	Resident	ce 6 € Other (Spe	cityLiving
n		on;	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b. Tin a <i>y Year)</i> Inju	iry	28c. Injun Worl			escrib <i>e</i> how	injury occurred	
isic	en or:	icat	2 Accident investigation 3 Suicide 6 Could not be	e and Blood of Ir	njury - At home, farm	M street lact		Yes 2 ☐ I		cation (Stre	et and Number or Ri	ural Boute Number
Division	lor Att after d Direct I in by t	Certification;	4 Homicide determined	building, e	tc. (Specify)	, 311861, Taul	ory, ornoe		Cit	ty or Town,	State)	arai riodio rvambor,
	Hospita 4 hours Funeral ely fillec	edical C			of examination and/						se(s) and manner as a and place, and due	
	To the within 2. To the Complet	Me	29b. Signature and title of certifier	(A)		. 2	9c. Licensi	e number		290	I. Date signed (Mont	h, Day, Year)
				Tea	En M.	0	D24	721			February 2	24, 2004
	6X'		30. Name and address of person who	completed cause of	death (Item 23a) (Ty	pe, Print)		1-4-				_ , ,
	U		Syed A. Sadiq,		333 Laure	L Bowi	e Rd.	#208	Laure	1, Md	20708	
	Sta Registi		31. Date liled (Month, Day, Year)	32. Regist	trar's Signature	H	Some	6. 9				

State of Maryland / Department of Health and Mental Hygiene

					Olato of	iviai yiai		tificate of	Death		Reg. No.	2001	06	85
	Physicia	an	1. Decedent's Name (First, Mid							2. Dete of De Month	Dey	Year	3. Time of De	
1	/Medic	al	Melvin Lev  4a Fecility Name (If not institut		traat and gumi				4b City Town o	Februa:	<del></del>		10:30	PM
1	Examin	er	Heartland Hea	_		-	delphi		Adel			ce Geo	raes	
	Funeral		5. Social Security Number	6. Sex	7		(ast birthday)	If Under 1 Year	If Under 24 Hr				ace (State or F	oreign
	Director		462-44-1923	10	M 2□ F <sub>2</sub>	72	Yrs.	Months Days	Hours Mir	s. 8. Date of Bir Month, Da Dec. 17	,1932	Texa	7y) 3	
	pue 👔	-	Usual Residence of Decedent 10a. Stete 10b. Coun	tv		10c. Cit	y, Town or Loc	ation				1	d. Inside City L	Limits
	Menyit f sho	ō		•	eorge's		delphi						Yes 2	
	r 28s	Je C	10e. Street end Number	ce de	orge s	А	derbur	10f. Zip Code			10g. Citizen of	What Coun	ry?	
	th wit		1801 Metzerot	t Roa	ad			20783			Ų:	ŞД		
0	ofter dee	by Funeral Director	11. Merital Status 1 ☐ Never Married 2 ☐ Ma		2. Was Deced Armed Ford Yes 2	<sup>es?</sup> □ <sub>No</sub> n/a	1		Hispanic Origin? ( pan, Mexican, Pue	Specify Yes or No no Rican, etc.)		ce - Americ ck, White,	atc.	
Ŏ	raff, c	d b	3 ☐ Widowed 4 🖺 Divorce	ed	If Yes, Give Year or Dat		1	☐Yes 2़्र्िNo	Specify:		Specify:Black			
<u>7</u>	"netu	To Be Completed	15. Decedo (Specify only high	ent's Educ es <i>t grede</i>	ation co <i>mpleted)</i>		16e. Deced	ent's Usual Occu	Occupetion cone during most of working a retired)  16b. Kind of Business/Industry cone during most of working a retired)					
7	withir ene. than	m C	Elementary/Secondary (0-12		College (1-4	or 5+)		Employe			US Gove	·+		
<b>D</b>	other other	ပ္	17. Father's Name (First, Middle	e, Lest)			AGO	Linproye	1	ame (First, Middle,			I.F	
/lar	Vente	9 8	Melvin Lewis	, Sr.					Ossiep	hine Wat	t			
lan	2 sho end h is me		19a. Informant's Name/Relation	t and Number or F				Code)						
≥ 0	l and Health m 27 her tr	J	Delma L. Hall	ım -	Sister	lanh f		Lockney ition (Name of atory or other pla	Ave., T	and the same of th			01-1-	
Baltimore, Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Meryland Depertment of Health and Mentell Hygiene.  Important: if then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other	emoval from St	ematory			ale, N						
3alt	emit. epertr nportu ny inji		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Latney's Funeral Home  3831 Georgia Ave., NW, Wash., DC 20011											
_	70 F 6 9		calph V	VU	lan	N	38	31 Geor	gia Ave.	,NW, Wasl	h.,DC 20	0011		
rec.	Physician	1	23a. P. rt1. Enter the diseese, shock, owneart failure. Li	or complic st only on	e cause on ead	sed The deat th line.	h. Do not ente	r the mode of dy	ing, such as cardia	ac or respiratory a	rrest,	1	Approximate Interval Betwee Onset and Dea	en ath
	/Medical Examiner		Immediate Cause (Final disease or condition	а	Arte	rioscl	erotis	Cardiov	ascular 1	Disease		:	years	
		7	resulting in death)  Due to (or as e consequence of):											
1	uted J ansit	E E	Sequentially list conditions  b. Due to (or as a consequence of):											
0	tificate be executed g physicien end es the buriel-trensit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			200 10 (0	r as a consequ	ionico orj.						
68760,	ete be hysici the bu	dical	Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last											
و ×	entific ding p	Med		L a										
8	ettend for us	Physician/M												
o	the de	nysi	Part II. Other elgnificant condit	derlying cause g	ven in Part I.		tobaccouse co Yee 2⊡ No							
ري ح	s thet	by P								10	188 2LINO	3   P100	ably 4124 On	KIIOWII
Division of Vital Records, P.O. Box	The lew requires that the death certificate be executed ate has been signed by the ettending physicien end page 2 should be deteched for use es the buriel-trensit	Completed									an autopsy rmed?	ava	re autopsy findi lable prior to apletion of caus eeth?	
~	The le	ĕ								10	Yes 21X No		Yes 2□ No	
Ita	ian: artifice ctor, I	B	25. Was case referred to medic examiner?	-						eath (Check only o	one)			
5	hysic this ce el dire	၉	1 ☐ Yes 2 ☐ No	H-			ER/Outpetient	3 DOA		Home 5 ☐ Resid			)	
ב	aling P	ᇣ	27. Manner of Death 1 ☑Natural 5 ☐ Pend	ing tigation	28a. Date of (Month,	Dey Year)	28b. Time of Injury	28c. Inju Wo M 1	nryat ork? ]Yes 2 □ No	28d. Describe i	now injury occur	red		
18	Attending Physician: r death. sctor: After this certific by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Coul		28e. Place of	Injury - At ho	ome, farm, stre	et, factory, office	7100 2 1100	28f. Location (S	Street and Numb	per or Rural	Route Number	r,
	s efter i Dire ed in b	Ser	4 Homicide	mineo	building	, etc. (Specify	y)			City or Tov	vn, State)			
	To the Hospital or Attending Physician: The lew within 24 hours effer death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai (				s of exemine			me, date and plac opinion, death occ					
	<b>Vithin</b> То the	Me	29b. Signature and title of certif	ier	1	1	(	29d Licen	se number		29d. Date signe	d (Month, E	lay, Yeer)	
			1 Pm	Qe.	nde	Un	) DO	01852	F	ebruary	25,2	004		
	2		30. Name end address of perso				, , , , ,	•						
			Paul A. Devore					ad, Hya	ttsville,	MD 2078	31			
	Stat Registra	_	31. Date filed (Month, Day, Yea		2004 P	istrar's Signa		4 1		-				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygieney 06856 For State Registra Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1:05 AM MARCH LIVINGSTON 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner NIA BALTIMORE HOSPITAL MOINE MEMORIA If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Day, 0] - 29 - Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex 1 M 2 ☐ F Days **Funeral** 213-48-1085 Hours 56 MD Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or 28a-f show was be redified at 1 XYes 2 □ No NA BALTIMORE Director mo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 3535 Items 23a AVENUE Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death variet Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23 min: If item treumatic event, the Modical Examination of other treumatic event, the Modical Examination. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 1 □ Never Married 2 Narried 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify: Specify: BLACK. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HAIR CARE BARBER 12 TH GRADE NIA Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WILMORE DAVID LIVINGSTON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1ANYA KICHNOR 212125 LIVINGSTON MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or 03.06.04 BANDAUSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FUNBRIL SERVICE Van 5151 BALTO. NATL PIKE, BALTO. MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DYSRHYTHMIA CARDIAC **Physician** ao mins disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medicai as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? ō 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 👿 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No certificate 1□ Yes 2 No 1 🗌 Yes Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 2 this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c. Injury at Work? Certification: After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation М death. 2 Accident in by the Director 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a To the Funerel [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier MAREPALLY 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifile INTERN- CCU AT 2438946 2004 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29 S PACA STREET MAREPALLY BALTIMORE SAPNA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 5 2004 A Registrar

ORIGINAL

			For Amend Items 23b,		rylan ,28a	d/Depa TperML Ce	artmer G228 rtifica	12/25/ 12/5/12	ealth a Oidhb Death	and M			20	04		
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last	LISTO	PAD						2. Date of De Month	\ Q	20	eer 0 T	3. Time of Dear	
نز	Examin Funeral	61	4a. Facility Name (If not institution, give 10445 HOPKINS  5. Social Security Number  6. Se	BAYVIEV X 7. Age		last birthday)	BI	r 1 Year	If Under:	RE	8. Date of Bir	th	County of		ce (State or For	eign
	Director		219-05-5125 18 Usual Residence of Decedent 10a. State 10b. County	M 2□F   8	10c. Cit	Yrs. y, Town or Lo		Days			July 2	8,19	19	Penn	Sylvani I Inside City Lir	nits
	vith the Ma or 28a-1 s	Director	10e. Street and Number	imore			10f. Zi	p Code		ndall	ζ	-	zen of Wha		/?	[140
36	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "naturel", or items 23e or 28e-f show event, the Musical Endrif er mind be notified at	by Funeral	2715 Creston Road  11. Marital Status  1 Never Married 25 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1⊠Yes 2□No  13. Was Decedent of Hispa						n, Mexican, Puerto Rican, etc.)					nited States  Race - American Indian, Black, White, etc.  ecify: White	
Maryland 21215-0036	within 72 hour ene. then "naturel	Completed b	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0·12) 8 Years	ucation	+)		dent's Usu kind of w DO NOT	ial Occupa ork done d use retired	ation during most	t of worki	ng				ss/industry	
yland 2	should be filed and Mental Hygis marked other umatic event.	To Be Co	17. Father's Name (First, Middle, Last) George Listopad						Al:	ice l	<i>(First, Middle)</i> Martin	, Maiden	Sumame)			
	s 1 and 2 should I Health and Men Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (T Mrs. Olga S. Lis				5 Cre	ston		Dui	d Route Numb ndalk,	Mary	land	212	22	
Baltimore,	Pages nent o ant: If I		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		0	emetery, cres	matory or Servi	other place Ce Co	orp.	1/21,	/2004	Т		ı, Ma	ryland	
Bal	permit. Departimports Imports sny inj	y 11	21. Signatur Funeral Service Licent	. Ca	u S	4.	7922	Wise	Ave.	Du	Home of ndalk,	Mary		212	22	ij.
	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. SUBDUE Due to (or as	AL	HEM uence of):	ATOM		g, such as	cardiac	r respiratory a	rrest,		9	oproximate nterval Between onset and Death	1
760,	ate be executed hysician and he burial-transit	Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):													O year	5
.O. Box 68	The law requires that the death certificat tite has been signed by the attending phy page 2 should be delached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	pregnancy		RTIFICALI			23d. Date of delivery Month Day Year							
<u>a</u>	quires that to signed by ald be deta	þ	Part II. Other significant conditions co Thrombocytopenia,	•							23e. Did t		_		cause of death	
Vital Records,		Completed	Fibrillation								24a. Was autor perfo 1 \( \text{Yes} \)		prio	r to comp	y findings availabletion of cause	able of
o	iding Physician: Th th. : After this certificate i funeral director. pag	tlon; To Be	25. Was case referred to medical examiner?  1 Y Yes  27. Manner of Death    Natural   5   Pending investigation	Hospital: 1 npatie 28a. Date of Inju (Month, Da) January 19	y Year)	ER/Outpatier 28b. Time o Injury	of A.	28c. Injury Work	er: 4 □ Nu ⁄at	rsing Hor	me 5 Residence Subjec	dence 6 how injury	occurred	(Specify)		
Division	To the Hospitel or Attending within 24 hours after death. To the Funeref Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury · At he c. (Specif	ome, farm, st		ry, office			28f. Location ( City or Tou 2715 Cres	wn, State)				
	To the Hospital within 24 hours of to the Funeral completely filled	Medical		rsician: To the best iner: On the basis of and manner sta	examina		vestigatio	n, in my op	pinion, dea							
>	To t To t	W	29b. Signature and title of certifier	MOLLD		- 00-1 (7		C. License	37	4		29d. Date	signed (A	Month, Da	iy, Year)	
5	⊸ Sta Regist		30. Name and address of person who of the control o	Johns Hor	151-5	Buyine-	1/1	Nical (	Cater	491	to End	in A	ven-e,	Bilh-	16 OM 20	224

/Medical Examiner Box.68760 Ö ۵. Division of Vital Records,

burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed physician use as the attending detached for the page 2 should be certificate funeral director. ihis After within 24 hours after death. To the Funeral Director: A filled in by completely the

Completed by Physician/Medical Examiner

Be

Certification: To

Medical

**Physician** 

Examiner

**Funeral** 

Director

23a or 28a-f show

or Items

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al Hygiene.

permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygies
Important: If item 27 is marked other th
sny injury or other traumatic event, IDS
ONCE.

**Physician** 

and

the Medical Examiner must be notified at

Direct

Funeral

þ

Be Completed

Maryland

deeth

filed within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sheed harles

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 0 5 2004

Suite 32. Registrar's Signature

29c. License number

D54664

203 Brewnieve, MD

29d. Date signed (Month, Dey, Year)

2-12-01

		ŀ	For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artmen <i>rtificati</i>	t of He e of E	ealth and i Death		jiene 1eg. No.	2004	06859
	2	š .	1. Decedent's Name (First, Middle,	Last)						2. Date of Dea	th Day	Year	3. Time of Death
	Physici /Medio		MARIE OLGA LEAC	H						MARCH		2004	11.50 P M
	Examir		4a. Facility Name (If not institution,		nber)		4b. City,		Location of Deat	h		County of Death	,002.
100			GILCHRIST CENTE				16 I I malan	TOWS	ON If Under 24 Hrs		_	ALTIMORE	
	Funeral		5. Social Security Number 212-07-1986	3. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.	Yrs.	If Under Months	Days	Hours Min.	8. Date of Birt (Month, Day		9. Birthi	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	2.	88					10/27/	15	MA	RYLAND
ì,	yland now		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Mar.	tor	MD BALTI	MORE		TOWSON							1 □ Yes 2 🕅 No
	or 28	)Ire	10e. Street and Number				10f. Zip	Code			10g. Citiz	en of What Cou	ntry?
	ath w 23e	Funeral Director	8117 LOCH RAVEN						286		US		
	er de	nne	11. Marital Status	12. Was Dece	rces?	J.S. 13. V	Was Deced f Yes, spec	dent of His city Cuban	spanic Origin? (S n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	1.	<ol> <li>Race - Ameri Black, White,</li> </ol>	
36	rs aft	by F	1 Never Married 2 Marrie 3 ☑ Widowed 4 Divorced	d 1 ☐ Yes If Yes, Give Year or Da	е **		1 🗌 Yes	2½ No	Specify:			Specify:	
21215-0036	72 hours after death with the Maryland natural; or items 23e or 28e-f show dical Examiner must be nuffied at	led	15. Decedent's	Education		16a. Deced	dent's Usua	al Occupa	tion		16b. Kin	d of Business/Ir	
215	within 7. ene. than 'n	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-	-4or 5+)	(Give	kind of wor DO NOT us	rk done di se retired)	uring most of wo	rking			
21	filed with Hygiene other tha	Con	12TH GRADE			SEC	RETAR	PΥ				CPA	
nd	be file d oth	Be	17. Father's Name (First, Middle, La	ast)					18. Mother's Na	ne (First, Middle,	Maiden S	Sumame)	
yla	ould to	ပ	JOHN R. SHANAMA							FINSTER			
Maryland	12 sho h and 7 is me reum		19a. Informant's Name/Relationshi  JANE G. KRENZER		ICI ICICIO		-			Iral Route Numbe	-		
1111	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-1 show or other treumatic event, It a Medical Examiner must be notified at		20a. Method of Disposition	DA	JGHTER 20b. 1	Place of Dispo	sition (Nan	ne of	E COURT	EDGEWOO Date		1D 2104 ation - City or Te	
Baltimore,	ages ont of t: If it		N☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	cemetery, crer	natory or o	ther place	. 1	5/04	ח זגם	IMORE,	MI
Ħ	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Li		PA	RKWOOD	CEME . Name an	TERY d Address					OME, P.A.
Ba	permit. Departr Importe any inje		Mathe M.	Xlaves		8	521 L	OCH I		VD. TOWS			
-	uladi		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that can	aused the deat							2 2 12	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Comi		101	siration	Vy fa	10	10	Oncot and Doath
	/Medical		resulting in death)	Due to (	o asía consec	quence of):	1	1	7. 1. 17 10	of toma	1		
-	Examiner		Sequentially list conditions,	b	por	selily	du	ero	mu	1 Tlorna	NATO	4 11 100	H
	pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (	or as a consec	quence of):	end	erta	in et	is log	4		week
	cate be executed physician and the burial-transit	xan	that initiated events resulting in death) Last	c	or as a consec					/			
8760,	cate be execut obysician and the burial-trar	dical E		d									
89	ificate g phy as the	edic		u.					and the second		-15		
Вох	death certifi e attending I od for use as	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregni		Ectopic pr	oanana.			23	3d. Date of delive	ery
	deat	sicia	in the past 12 months? 1 □ Yes 2 ⋈ No		ant at time of o		Other (sp					Month	Day Year
0.0	that the death certifi ed by the attending I detached for use as	Physician/Me	9 ☐ Unknown \										
	S C 0	þ	Part II. Other significant condition	s contributing to de	ath but not res	sulting in the u	nderlying c	ause giver	n in Part I.	23e. Did to	2		ne cause of death?
Records,	w require been sig should b	Completed	rance for	12	1 -								
3ec	The law ate has b page 2 st	Jdw	Ceron my o	trtery	dis-	esse				24a. Was a autop perfor	SV	24b. Were auto prior to co death?	psy findings available mpletion of cause of
al F										1 Yes	2 <b>2</b> 0No		2□ No
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:		150/0		Other		th (Check only or			11.
of	Phys r this eral dii	$\vdash$	27. Manner of Death	28a, Date o	of Injury	ER/Outpatien 28b. Time of		8c. Injury	at	lome 5 Resid			N) Hogico
ion	Attending I r death. ector: After by the funer	atlor	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investiga		h, Day Year)	Injury	М	Work1 1 □ Y	? es 2 □ No				
Division	Attendi er death. ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place	of Injury - At h	ome, farm, str	eet, factory	, office	-	28f. Location (S City or Tow	treet and	Number or Rura	Il Route Number,
Ö	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:		Duildii	.g, 5.2. (5pool	,,				2, or 10W	., 5,210)		
	Hospi 4 hou Fune ely fil	ical	(Check only 2 Medical E.	Physician: To the kaminer: On the ba	isis of examina	owledge, death	occurred vestigation,	at the time	e, date and place inion, death occu	, and due to the o	ause(s) a ate and p	and manner as solace, and due to	tated. the cause(s)
	To the Hospitel within 24 hours of To the Funerel I completely filled	Medical	one)  29b. Signatur and life of contifier	and mann	er stated.			. License				signed (Month,	
	1 × 0		V An-	D 1	E.	and							
	2		30. Name ind address of person w	ho completed cause	a of death (Ite	m 23a) (Type	Print)	-			. ( )/	-4 -1.	
	10		WA REL	ey (+3	1	6701	M.C	Char	le St.	Bolto.	md	2020	S
13.0	Sta	ate	31. Date filed (Month Day Year)	2004 32. Rg	gistrar's Sign	ature	A				-02		**
	Regist	rar	warut U e	2 5004	114000	AN A	<b>京村</b>	1					

Leach, Manie expiner 3-2-04,115pm

			1 - For State Ragistrar		aryland / De	epartment of liberation	Health and M	ental Hygier	•	06860	
			1. Decedent's Name (First, Middle, Last,	)				2. Date of Death	TO THE LAND OF THE PARTY OF THE	3. Time of Death	
	Physici		Kenneth B.	Mer	tel			MARCH	Day 200	46:30 AM	
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea		
			NORTH ARUNDE	- Hosfin	TAL	CILEN	BURNIE		A /1	RUNDEL	
	Funeral		5. Social Security Number 6. Sec	7. Age	(In yrs. last birtho	(ay) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth		thplace (State or Foreign	
¥.	Director		212-30-9628 <sup>12</sup>	]M 2□F	69 Yr	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea Sept. 30	1934	ountry) MD	
_	pu *		Usual Residence of Decedent  10a. State 10b. County	1	10c. City, Town o	- Leastine					
٠.	aryla shov	5			Toc. City, Town o		1			10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
4	ith the Marylar or 28a-f show re notified at	Director	Maryland Anne Aru	ınde i		-T	adena				
	ours after death with the Maryland 'st', or Itams 23e or 28e-f show Examinat must be notified at	급	8438 Garland Road	ŧ		10f. Zip Code	21122	10g. (	Citizen of What C		
工	leath w	Funeral		12. Was Decedent E	ver in U.S.	13 Was Decedent of I	14. Race - Am				
111 00	fter d	돌	1 Never Married 2 Married	Armed Forces?	0	<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>		Rican, etc.)	Black, Whi	te, etc.	
3.8	hours after tural', or Its al Evantion	by	3 X Widowed 4 ☐ Divorced	1 ⊠ Yes 2 □ N If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White	
KENNET 215-0036		Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. D	ecedent's Usual Occup live kind of work done e. DO NOT use retire	pation	16b.	Kind of Business	/Industry	
7 2	thin Bn .	ple	Elementary/Secondary (0-12)	College (1-4or 5-	+1			ig			
27	ed wi	ပ္ပ	12			Truck Driv	er		Trailer		
ERTEL Maryland	S should be filed within and Mental Hygiene. Is marked other than sumatic event, the Ma	Be	17. Father's Name (First, Middle, Last)					(First, Middle, Maide	•		
y sa	should nd Men marke umatic	5	Harry Mertel				Unice				
اع لم	2 sho		19a. Informant's Name/Relationship (Ty			ailing Address (Street					
	s 1 and 2 should be filed within 72 hd Health and Mental Hygiene. Item 27 Is marked other than "nature other traumatic event, the Madical		Vaughn R. Shinaberr	y (brothe		8438 G sposition (Name of	arland Roa				
(M Baltimore,	e = 5		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery,	crematory or other pla	ce) March	ate 1 09	Location - City or	Town, State	
‡	nit. Pa vartmen ortant: injury		*4 □Donation 5 □Other (Specify)	$\sim$	cedar. H	ill Cemete	200			Maryland	
Bal	Departing on its procession of the procession of		21. Signati re if Funeral a rvice Lyers			22. Name and Addre		Stallings	Funeral	Home, P.A.	
	40144		and a	1			ntain Road		a, MD 21		
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused	ine death. Vo not e.	enter the mode of dylf	ng, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death	
	Physician (Madisəl		Immediate Cause (Final disease or condition resulting in death)	const	stre	neent	factors	le		Onset and Death	
5.	/Medical Examiner			Due to (or as a	consequence of):	0	U				
		-	Sequentially list conditions,	Due to for as a	consequence of):	AVE					
L.T	ted nsit	-Fu	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	i hicker	Consequence (ii).	and in	na cht				
M	be execut ician and burial-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):	( de la como de la com	and Salva	<i>y</i>			
99	siciar buri	cal E			,		· ·	,			
282	eath certificate attending physi for use as the l		0	•							
×	n certi	/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o					23d. Date of del		
ĕ	eath atter	clar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		3 □Ectopic pregnancy 5 □ Other (specify) _	<b>Y</b>		Month	Day Year	
o.	t the de by the tached	Jysi	9 Unknown	9□ Unknown							
Division of Vital Records, P.O. Box 68	w requires that been signed b should be deta	by Physician/Medi	Part II. Other significant conditions con	tributing to death but	t not resulting in th	e underlying cause giv	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?	
rds	quires n sign							1 ☐ Yes 2	2□No 3□Pr	obably 4 Unknown	
8	s bee	Completed						24a. Was an	24h Were au	Itopsy findings available	
Re	The lav	E C						autopsy performed?	prior to death?	completion of cause of	
tal	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Death		o 1 ☐ Yes	2 No	
<u> </u>	ysicii is cer direct	0	examiner?	ospital: 1 X Inpatien	t 2□ER/Outpa	tient 3 DOA Oth	The second second	e 5 Residence	6 DOther (Con	7.5.1	
0	g Ph er th	n: T	27. Magner of D ath	28a. te of Injury (Month, Day		e of 28c. Injur		8d. Describe how inju		лу)	
Ö	Attending P death. ctor: After y the funer	atlo	1 ANatural 5 Pending 2 Accident investigation	(Month, Day	Year) Injur		k? Yes 2 □ No				
<u>Vis</u>	er de	ii	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur	y - At home, farm,	street, factory, office	21	8f. Location (Street a	nd Number or Ru	ral Route Number,	
Ō	s after safter all Din	Certification;	TIOMING	building, etc.	(Specify)			City or Town, Star	e)		
	Hospital or Attending Physician: The law requires that the death certifical 4 hours after death. Funeral pirector: After this certificate has been signed by the attending phytelety filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying Phys	ician: To the best of	my knowledge, de	eath occurred at the time	ne, date and place, ar	nd due to the cause(s	s) and manner as	stated.	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one)	and manner state	ed.	investigation, in my o	pinion, death occurred	d at the time, date ar	d place, and due	to the cause(s)	
	To the within 2 To the comple	Σ	29b. Signature and title of certifier			29c. Licens	e number	29d. D:	ate signed (Month	n, Day, Year)	
	,		不是	W	D	04	3977	Wien	uh 5 :	20014	
	2		30. Name and add s of person who co	mpleted cause of de	ath (Item 23a) (Typ	pe, Print)	A COMPLETE			-	
_			United Witness	NO) TRAPA	tal Ben	vi lilen	Brime:	n2. 2	1061		
	Sta Registr	_	311 Date filed (Month, Day, Year)	32. Registrar	s Signature	4 draw	17 -				

				For State	State of Marylar	nd / Departme	ent of F	lealth and Me	ental Hyg	giene 200	4 06861
	10	7		Registrar  1. Decedent's Name (First, Middle, Las		Certific	ate of	Dealli	2. Date of Dea	Reg. No.	3. Time of Death
		Physici /Medic		JOHN	N.	MASO	N	F	Month	Day Year Year 28, 2002	1 i.ET O.
		Examir		4a. Facility Name (If not institution, give	A 4		ity, Town, o	r Location of Death		4c. County of Dec	
	\$ 1 . S	Function	-	5. Social Security Number 6. S			HAU der 1 Year	If Under 24 Hrs. 8	. Date of Birtl		oRD rthplace (State or Foreign
Š.		Funeral Director			M 2□F 8	Yrs. Mont	hs Days	Hours Min.	Date of Birtle (Month, Day EBRUAR	Y 20,1920 V	VEST VIRGINIA
11.		and w.		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Location					10d. Inside City Limits
		Maryland	tor	MARYLAND BALTI	NORE D	UNDALK					1 Tes 2 No
		ith the	Oirec	10e. Street and Number	2011		Zip Code			10g. Citizen of What C	ountry?
7		death with the rns 23a or 28a rns 1 te noti	Funeral Director	2905 DUNM	JRRY ROAD  12. Was Decedent Ever in U		212		fu Vac or No-	14. Race - Am	erican Indian
2/28/0	٥	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene 1 fleatural; or Items 23a or 28a-f show filem 27 is marked other than "natural; or Items 25a or 28a-f show other treumatic event, the Modical Examiner manable multiled at	by	Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		specify Cub	dispanic Origin? (Specian, Mexican, Puerto Ri Specify:	can, etc.)	Black, Wh	
3	<u>ဂ</u>	natul	Completed	15. Decedent's Ed (Specify only highest gra		16a. Decedent's U (Give kind of	sual Occup work done	pation during most of working d)		16b. Kind of Business	s/Industry
3	1212	within lene. then "	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		NAN			WESTERN	FIFTRIC.
		should be filed within and Mental Hygiene. marked other than tratic event, it a M	Be C	17. Father's Name (First, Middle, Last)	۸ ۸ ۰		1911-	18. Mother's Name (	First, Middle,		Cocinis
		ould b Mentinarked harked	To	DAVID K	. MASOR			VIRGIA			NO
	Z Z	th and 27 is in treum		19a. Informant's Name/Relationship (	Sype, Print)	196. Mailing Addr	ess (Street	and Number or Rural I	Route Numbe	r, City or Town, State,	ZID CODO) MD 21222
55	ē,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or othar treu once.		20a. Method of Disposition		Place of Disposition (incometery, crematory)	Name of or other place	Dar	0	20c. Location - City of	41
3. S.	altimore,	Page ment c ant: If ury or		1 ☐ Burial 2 📉 Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State	ANS FUNE	ERAL	IR MARCH 2	2004	FOREST H	ALL, MD
-	g Rail	Depart Depart Import any in		21. Signature of Funeral Service Licen	see	25					VES FUNERAL
	-38	Ale To		23a. Part1. Enter the disease, or comp	olications that caused the deal				,		MONI UM, MD Approximate
		Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	ASC V D						Interval Between Onset and Death
		/Medical Examiner		resulting in death)	Due to (or as a consec	juence of):					7)
A.W.			e	Sequentially list conditions, if any, leading to immediate	b. Hyperter or as a consequence	puence of):	0	A			gears
_		outed ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	Mocard	A	TOUCE	tion			recent
740	ွှ်	cate be executed physicien and the burial-transit	I Ex	resulting in death) Last	Due to (or as a consec	quence of):					
			dicai		d						
36	XOP	death certific e attending p ed for use as	m/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnation 1 Live birth 2 ☐ Feta	ancy al death 3 ⊟Ectopic				23d. Date of de	livery
11	o o	0 0 0	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of o			·		Month	Day Year
(	<u>.</u>	requires that the een signed by th nould be detache	/ Phy	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlyin	g cause giv	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
-	Sp	w requires been sign should be	ed by						1 🗆 Y	es 2□No 3□P	robably 4 Unknown
	or Vital Records,	> 0 10	Completed						24a. Was a		utopsy findings available completion of cause of
	Î.	ıysicien: The lav is certificate has director, page 2	Com						perfori	med2 death?	s 2□ No
	<u> </u>	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☑	ED/Outration 20	DOA Oth	26. Place of Death (			
		ਜ਼ੁਵ ਜ਼ੁਵ	n: To	27. Mann Death	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	28c. Injur Wor			ence 6 Other (Spe ow injury occurred	ecity)
Fo.	SIO	Attending r death. sctor: After y the fune	catio	1		М	1 🗆	Yes 2 No			
6	DIVISION	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specil	ome, farm, street, fact (y)	tory, office	28	Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
Mason	_	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	owledge, death occurr	ed at the tir	ne, date and place, and	d due to the ca	ause(s) and manner a	s stated.
5		the Ho nin 24 the Fu	Medical	one)	iner: On the basis of examina and manner stated.						
		To vitt	2	29b. Signaturerand title of certifier	VAN EDREMENT	Phusician	29c. Licens	HANKL77	2	9d. Date signed (Mont	n, Dey, Year)
		ſ		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type, Print)	ן עיין	1000011	1 /	110001	ary
		6		TEFFREY A. COI	IAN DO. Uppo	· Chesageo	eke Me	dical Centa	5.500ll	perChesase	eake Drive Bellir M
	No.	Sta Registi		31. Date filed (Month Cay, Year) MAR 0 5 20	32. Pogistrar's Signa	A Angel	2 11		/		

		1 - For State Registrar	State of Maryla	nd / Depa	artment of H	lealth a	nd Mental	Hygien		06862
		Decedent's Name (First, Middle, Las	")				2. Date Mon	of Death		3. Time of Death
Physic /Med		Betty Marie Meyer					Marc	h 1,	ay 2004 Year	2:55 P M
Exami		4a. Facility Name (If not institution, give			4b. City, Town, or		Death	4	c. County of Dea	ith
	Н	Shady Grove Advent			Rockvill	lf Under 2	A Hrs   0 Date		Montgome	
Funera		5. Social Security Number 6. Se 11	7. Age (in yrs	s. last birthday) Yrs.	Months Days	Hours	Min. (Mon	of Birth th, Day, Yea h 19,	7)1916	rthptace (State or Foreign Country) Canada
Director		Usual Residence of Decedent					7.012			
death with the Maryland me 23s or 28s-f ehow rmst be notified at		10a. State 10b. County	10c. C	City, Town or Lo	cation					10d. Inside City Limits 1 X Yes 2 ☐ No
Ba-1 •	cto	Maryland Montgomen	ry Ro	ckville				100		
vith th	Funeral Directo	10e. Street and Number 9701 Medical Cente	w Dwire		10f. Zip Code 208	250			Citizen of What C nited St	
e 23s	erai		12. Was Decedent Ever in	118 13			in? (Specify Yes		14. Race - Am	
ter de	Ę.	11. Maritat Status  1X Never Married 2 Married	Armed Forces? 1 ☐ Yes 25 No		Was Decedent of H If Yes, specify Cuba		Puerto Rican, e	tc.)	Black, Wh	ite, etc.
urs al	þ	3 ☐ Widowed 4 ☐ Divorced	tf Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:			Specify: W	hite
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or frame 23a or 28a-1 show event, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra-		16a. Dece (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most	of working	16b.	Kind of Business	s/Industry
A digital	ld m	Elementary/Secondary (0-12)	College (1-4or 5+)		dministra	ıtive		M.	anufactu	irina
of filed within all Hygiene.		17. Father's Name (First, Middle, Last)	4	1	Associat		r's Name (First, I			ILTIIG
Viand ould be file Mental Hy arked oth	To Be	Grover John Meyer				Isal	bel McCa	.nn		
	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street	and Number	r or Rural Route	Number, City	or Town, State,	Zip Code)
2 5 # 2 F		Isabel Meyer Furlo		4101	Cathedra	l Ave	., #/10.	Washi	ngton,	DC 20016
ore, less 1 and of Healt If Item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	Place of Dispo cometery, crei	sition (Name of matory or other place somery	<sup>(в)</sup> Ма	Date arch 2,	20c.	Location - City o	r Town, State
Pages tment of tant: If It glury or o		* 4 □ Donation 5 □ Other (Specify	)   C1	emator.	Lum, Inc.		2004	Bet	hesda,	Maryland
Baltimore, permit. Pages 1 at Department of Her Important: If Item any injury or othe		21. Signature of Funeral Service Licen	M00689	Be	thesda/C Bethes	hevy ( da. Ma	Chase, I aryland	nc 75 20814-	pnrey F 57 Wisc -3501	uneral Home/ onsin Avenue
		23a. Rart1. Enter the disease, or companies or heart failure. List only	plications that caused the de	ath. Do not ent	er the mode of dyin	ng, such as o	cardiac or respira	tory arrest,		Approximate Interval Between Onset and Death
Physician	_	Immediate Cause (Final disease or condition	a Aldu	ance	d D	concy	11.9			Onser and Deam
/Medica Examine		resulting in death)	Due to (or as a conse	equence of):						
1%		Sequentially list conditions, if any leading to immediate	b Due to (or as a conse	equence of):						
uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
750, le be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a conse	equence of):						
2 2 2 2	cai		d							
C 68 artificat ing phy e as th	Med	IF FEMALE:								de 18
BOX sath cert attendin for use	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3	Ectopic pregnancy Other (specify)	/			23d. Date of de Month	elivery Day Year
I RECORDS, P.O. BOX 68 The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as it	by Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	death 3L						
cords, P.O.  vrequires that the deben signed by the should be detached	y P.	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.	236	. Did tobacco	use contribute	to the cause of death?
rds quires n sign								1 🗌 Yes	2 □ No 3 □ F	Probably 4 Unknown
Records, he law requires t e has been signe tge 2 should be o	Completed						24a	. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
Hee The lav	E						10	performed? Yes 2 2	death?	s 2 No
Vital F sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					of Death (Check	only one)		
Of V Physic this o	2	1 ☐ Yes 2 ☑ No		☐ ER/Outpatie		4 million	rsing Home 5	Residence		ecify)
Division of VIta or Attending Physician: after death.  Director: Atter this certification by the funeral director.	lon:	27. Manner   eath  1   eath   5   Pending   investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	ya≀ rk? Yes 2.⊟N		SCHOO HOW IN	july occurred	
Attend death ctor: y the	ficat	3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, st			28f. Loc	ation (Street	and Number or F	Rural Route Number,
Div after dib	Certification;	4 Homicide	building, etc. (Spe	cify)			City	or Town, Sta	ite)	
Division of Vital Refunding Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director.	Medical (		ysician: To the best of my k niner: On the basis of exami and manner stated.							
To the Within To the	Me	29b. Signature and title of certifier		MT	29c. Licens	se number	459=	29d. C	Date signed (Mor	nth. Day, Year)
9		30. Name and address of person who	completed cause at don't (to	em 23a) /Tuna	Print)	9 01	d 1 2	0		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
0		SU. Name and address of person who	Completed cause of death (III	23a/ (1ype,	Sulle Sulle	att 4	04 B	0.10	er she	J- NO 20910
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature		,,,,,	1, ( )			
Regis	strar	MAR 0	5 2004 Len	reper	6 h	soll.	, -			
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		1 - For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Ma	iryland / E	Cert	rtment of H	ealth and Death	Mental Hy	Reg. No	2004	06863
Physici /Medic		Rita Kamerman Morn						Februa Februa	ry 2	8, 2004	11:09P M
Examin	er	4a. Facility Name (If not institution, give s  Vantage House  5. Social Security Number 6. Sex		(In yrs. last bir	thday)_	4b. City, Town, or Columbi If Under 1 Year		· 8 Date of Bi	H	County of Deat	h hplace (State or Foreign untry)
Funeral Director			]M 2∏F	92	Yrs.	Months Days	Hours Min.	May 27	, 19	11 Pola	and
Maryland	tor	10a. State 10b. County  Maryland Howard		10c. City, Town		ation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
death with the Maryland ms 23a or 28a-f ehow Finust be multing at	al Director	10e. Street and Number 5400 Vantage Point	Road			10f. Zip Code 21044			_	tizen of What Co ced Stat	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Department of Health and Mentat Hygiene. Important: If item 27 is marked other than 'naturel', or items 23a or 28a-f show apprintury or other traumatic event, the Medical Exaction at most be inclined at ance.	by Funeral	11. Maritat Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		1	as Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, White Specify: Whi	etc.
ithin 72 ho ne. hen "natur hedicul	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5	+)	(Give k life. Di	ent's Usual Occupa ind of work done of O NOT use retired	furing most of wo	rking		(ind of Business/	Industry
i be filed w nta! Hygier ed other tl	Be	17. Father's Name (First, Middle, Last)	2	Pu	rcha	asing Age	18. Mother's Na			ood Comp	any
d 2 should th and Mei 7 is mark traumatic	2	Bernard Kamerman  19a. Informant's Name/Relationship (Ty)				Address (Street a		ıral Route Numb	-		
Pages 1 and neut of Heal out: If item 2 iry or other		Syde1 Maher/ Daugh  20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ R  1 □ Donation 5 □ Other (Specify)		20b. Place of cemeter Montgo	Disposi y, crema mer	yland Dr ition (Name of atory or other plac y ium, Inc	Marc	Date h 4,	20c. Lo	cation - City or Tand Market	Town, State
pemit. Deportruitments Imports any inju		21. Signature   Funeral Service License		1353	Bet		s of FacilityRol	pert A.	Pump 755	hrey Fur 7 Wiscon	neral Home/ nsin Avenue
Priysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Neurodes Due to (or as a  Non Insu Due to (or as a	enerati consequence lin Dep consequence	ve D of): ende of):	isease			ırrest,		Approximate Interval Between Onset and Death Ten Years
ficate be physicia ts the bur	edicai	IF FEMALE: 23b. Was decedent pregnant	oue to (or as a			Ectopic pregnancy				23d. Date of deli	
w requires that the death certif been signed by the attending should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4☐ Pregnant at t 9☐ Unknown	time of death	5 🗆 (	Other (specify)				Month	Day Year
The law requires that the death cert lite has been signed by the attending bage 2 should be detached for use a	þ	Part II. Other significant conditions con	tributing to death bu	it not resulting in	the und	derlying cause give	in in Part I.		Yes 2	_	the cause of death?  bably 4 Unknown
: The law cate has b page 2 st	Completed							24a. Was auto perfe 1 \(\sum \text{Yes}\)	psy ormed?	prior to c death?	opsy findings available ompletion of cause of 2 No
To the Hospital or Attending Physician: The law within 24 butus after death, within 24 butus after death.  To the Funeral Director: Attent this certificate has completely filled in by the funeral director, page 2.	ion; To Be	27. Manner of Death 1 XNatural 5 □ Pending	ospital: 1  Inpatier 28a. Date of Injun (Month, Day	28b. T	tpatient Fime of njury	28c. Injury Work	at ?		dence	6 □Other (Spec ry occurred	ily)
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubutding, etc		rm, stree		∕es 2 □ No	28f. Location ( City or To			ral Route Number,
ne Hospita 7 24 hours ne Funera pletely fille	edical C	29a. Certifier 1 Table Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of ter: On the basis of and manner stat	examination and	death of	occurred at the time estigation, in my op	e, date and place linion, death occu	o, and due to the arred at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
To the within To the To the Comp	W	29b. Signature and title of certifier	Milles	MO		29c. License D2662				te signed (Month $h 1, 200$	
Sta	te	30. Name and address of person who co Gary Milles, M.D., 31. Date filed (Month, Day, Year)	10700 Ch 32. Registra	arter D	rive	, Columb			044		
Registr	- 15	MAR 0.5	2004	Thorne were	-	A for	and I	#			

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	Co	ertificate of	neaith and it Death	лептат пуд в	eg. No. 200	4 06864
	Physici	an	Decedent's Name (First, Middle, L.					2. Date of Deat Month	th Day Yea	3. Time of Death
	/Media		JULIUS	ROBERT	MA	ZER		MARCH	2, 200	
	Examir	er	4a. Facility Name (If not institution, ga	ive street and number)			r Location of Death		4c. County of De	
			NOR TITWEST  5. Social Security Number 6.	Sex 7. Ad			If Under 24 Hrs.	O Date of Birth	BALTI	
e.	Funeral Director			1 M 2 F	e (In yrs. last birthda 82 Yrs.	Months Days	Hours Min.	8. Date of Birth 001 10	,1921 M	irthplace (State or Foreign ARYLAND
	and		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary f sh	tor	MD N//	I	BALTIM	ORF				1 □Yes 2 □ No
	the	rec	10e. Street and Number	·		10f. Zip Code		1	0g. Citizen of What (	Country?
	3a of	Funeral Director	3601 CLARKS LAN	- <b>#41</b> 8		2121	5		USA	•
	deatl	Jere	11. Marital Status	12. Was Decedent	Ever in U.S. 13	B. Was Decedent of H		ecify Yes or No-	14. Race - An	nerican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or othar traumatic event, If a Medical Examiner must be notified at angles.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Wes 2 1  If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	an, Mexican, Puerto  Specify:	Hican, etc.)	Specify: W	
5-0	72 ho	etec	15. Decedent's ( (Specify only highest g	Education		edent's Usual Occup re kind of work done		ina	16b. Kind of Busines	s/Industry
7	ithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+) life	DO NOT use retired	d)	"'y		
	led w lygier her th		12		0	WNER			SH0ES	
ind	be fill d ott	Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Name	ə (First, Middlə, N	Maiden Surname)	
Maryland	should be filed withir nd Mental Hygiene. s marked other than umatic event, the Man	٩	JOSEPH		MAZER		ROSE			SCHEIR
Mai	12 sh h and 7 is n traun		19a. Informant's Name/Relationship			ling Address (Street			1	1 14125
	1 and Healt In 2		MARC W. MAZER  20a. Method of Disposition	_ / SON		KENNINGTO position (Name of				
Baltimore,	permit. Pages 'Department of the Important: If Ite any injury or ot once.		1 Durial 2 Cremation 3 1 4 Donation 5 Other (Spec	ify)	BETH TF	ELOH CONG.	MAR.4	,2004	WOODLAWN,	MARYLAND
Ba	permil Depar Impor any in		21. Signature of Funeral Sarvice Liga	wille		22 Name and Addre SOL LEVINS 8900 REIST	ss of Facility 50N & BROS FERSTOWN I	F.H. D., PIK	INC ESVILLE, M	1D 21208
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused y one cause on each lin	the death. Do not e	nter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· m	yo cardial	Infarct	ion			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as.	consequence of):	J				
346	LAGIMINE	_	Sequentially list conditions,	b						
146	ed isit	line	Sequentially list conditions, it is labeled to the cause. Enter Underlying Cause (Disease or injury	Disa to (or sis	a consequence of):					
	and and II-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit									1
687	ficate phys	adic		d						
Box	nding use a	Š	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	divery
m	that the death cer ed by the attendir detached for use	by Physician/Medical	in the past 12 months?	1□Live birth 4□Pregnant at		☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year
P.O.	t the by the ache	hys	9 Unknown	9□ Unknown						
S,	es tha igned be det	y P	Part II. Other significant conditions	contributing to death be	ut not resulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rd	w require been sig should b							1 🗆 Yes	s 2□No 3□F	robably 4 Unknown
Vital Record	e law re has be je 2 sho	Completed						24a. Was an		utopsy findings available
œ	ysician: The la is certificate has director, page 2	E		-				autopsy perform 1 Tes 2	ted? death?	completion of cause of
ta	ician: Th certificate ector, pag	Bec	25. Was case referred to medical				26. Place of Death			20110
	Physician: this certificatal director, i	10	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	nt 2 ER/Outpatie	ent 3 DOA Othe	er: 4 Nursing Ho	me 5 Resider	nce 6 □Other (Spe	ecify)
0	ding Phy th. After thi funeral	ü	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Da)	y Year) 28b. Time Injury	of 28c. Injun	/ at	28d. Describe how	w injury occurred	
Sio	Attending ir death. ector: After by the funer	atle	2 ☐ Accident investigation			M 1 🗆	Yes 2 □ No			
Division of	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not lead to determine determined		iry - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	lural Route Number,
_	spital ours cours neral filled	<u>S</u>	29a. Certifier Certifying P	hysician: To the best of	of my knowledge dea	th occurred at the tim	ne date and place	and due to the car	uso(a) and manner	
	To the Hospital or A within 24 hours after To the Funeral Direconcletely filled in by	edical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examination and/or i	nvestigation, in my or	pinion, death occurr	ed at the time, da	te and place, and du	s stated. e to the cause(s)
	with with To the come	Σ	29b. Signature and title of certifier			29c. License	number .	29	d. Date signed (Mon	th, Day, Year)
)	4		Dintson	m.D.		Do	5 9 7 3 6	C	march &	2, 2004
	10		30. Name and address of person who		eath (Item 23a) (Type				merch 2	
		_	DEFORMA JAMES	M.D.	46.0円を進まて	HARMEN	Mar OLD	Circle?	to to Pm	ANUTONI
	Sta	-	31. Date filed (Month, Day, Year)	1/ 1/	r's Signature	South			Section - Control	
1 6	Registr	ır I	MAR 0 5 2004	J. Berger	for 1	en south				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 06865 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Edward John Novak Jr. 9:45PM MARCH 03,2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 11, 1940 Maryland 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**⊠** M 2□ F 63 Director 214-40-6840 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r then "natural", or Itams 23a or 28a-f shov the Medical Examiner must be notified at Baltimore 1 ☐Yes 2 No Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 423 Margaret Ave. 21221 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify SpecifiWhite þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Beth Steel Machinist 2yrs if Health and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward J. Novak Sr. Marie Marchsteiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn D. Novak / wife 423 Margaret Ave.Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of the Important: If its any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State GardensofFaith 3/6/04 Rossville MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex permit 21. Signature of Funeral Service Licensee onne 300 Mace Ave. Baltimore MD 21221 23a. Part 1. Enter the disease, or combications that caused the death po not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only pine cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760, Physiclan/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death ò in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 Yas 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 90 CHRONIC RENAL FAILURE 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed?

1 Yes 2 No certificate has page 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Alter 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 within 24 hours after To the Funeral Dire Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 3, 2004 lou, D 17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 Date filed MARO 3 3ar 2004 HELDI M. D. 7 7601 OSLER DRIVE TOWSON, MARYLAND 21204

DHMH 17 Rev 1/2001

State

Registrar

De com

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** John H. 0'Connell March 2004 9:04A /Medical 4e. Fecility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery 8. Date of Birth (Month, Dey, Year) April 18,1933 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Illinois 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2□ F Yrs. 70 **Director** 337-26-2824 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational Demolitical and ORGS. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director Silver Spring Montgomery Maryland| 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3163 Adderley Court 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Electronics Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Herbert O'Connell Ruth Henaghan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marcia O'Connell/Spouse 3163 Adderley Court; Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Crematory 03/03/2004 Baltimore, MD 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 21. Signature of Funeral Service License enthy 1040 Rockville Pike; Rockville, MD 20852 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Rectal Cancer /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisease or injury) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2**∑** No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 1 ☐ Yes 2 ▼No 2 ER/Outpatient 3 DOA 은 After this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: 1 X Natural 5 Pending after death.

Director: Af
I in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 1🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and two 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison, MD 6001 Muncaster Mill Road; Rockville, MD 20855 2. Registrar's Signature 5° 2004 State Registrar

			For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of rtificate o	Health a	nd Men	tal Hygie	ne 2	004	068	67
	Physici	an	Decedent's Name (First, Middle	, Last) Philip Lee	O'Connell				Date of Death Month	Day 2.5	Year	3. Time of De	eath
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	ZAGIIII		Potomac Valle	y Nursing	Center	Rockvi	ille			Mont	gomer	У	
	Funeral			6. Sex 7. A 1 X M 2 ☐ F	ge (In yrs. last birthday)	If Under 1 Yea Months Day		Min.	Date of Birth Month, Day, Y	ear)	Coun	lace (State or F	
	Director		020-18-1475 Usual Residence of Decedent		83 Yrs.			Au	ıg. 11,	1920	Massa	chusett	S
	yland how		10a. State 10b. County		10c. City, Town or Lo	ocation					1	0d. Inside City I	Limits
	Be-f	ctor	Maryland Montgo	omery	Roc	kville						1⊠Yes 2	□ No
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9	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28e-f show event, the Mudical Examiner round be notified at	Fun	1 Never Married 2 Marrie	Armed Forces  1 X Yes 2  If Yes, Give	] No	Was Decedent of If Yes, specify Cu		Puerto Rica	n, etc.)	ВІ	ack, White,	etc.	
200	ural;	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	WW II	1 ☐ Yes 2 🛣 N				Spec	wy: Whi	te	
רַל	n 72 l	Completed	15. Decedent' (Specify only highest	grade completed)	(Give	dent's Usual Occ kind of work don DO NOT use reti	e durina most d	of working	16	b. Kind of	Business/Ind	lustry	
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2	al Hyg	Bec	17. Father's Name (First, Middle, L				18. Mother	s Name (Fir	st, Middle, Mai				
<u>X</u>	ould b Ment Marked Marked	10	William D. O'C				1	trude					
Maryland 21215-0036	es 1 and 2 should be fi of Health and Mental F filtem 27 is marked ot ir other traumatic ever		19a. Informant's Name/Relationsh Daniel W. O'Conr			ng Address (Stree				•			
	Heal Heal tem 2		20a. Method of Disposition	icii/ bon	20b. Place of Dispo	Ednor Ro		Date			Land Z		
saitimore,	Pages nent of nnt: If it iry or o		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		Center C		<sub>Iace)</sub> Ма	arch 2 2004			eld, ssachu		
a	permit. Page Department Importent: If eny injury o		21. Signature of Funeral Service L		22	. Name and Add	ress of Facility						
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			23a. Part1. Entey the disease, or o shock, or heart failure. List of	complications that cause only one cause on each	ed the death. Do not ent	er the mode of dy	ying, such as ca	ardiac or res	piratory arrest,			Approximate Interval Betwee Onset and Dea	en
	Physician / /Medical	ñ	Immediate Cause (Finaf disease or condition resulting in death)		lac Arrythm	ia					M	linutes	
	Examiner				s a consequence of): al Fibrilla:	tion					W	onths	
		Jer	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	s a consequence of):	CIOII					1	onens	
4	nd nd transit	Examiner	triat initiated events	C	tension						Y	ears	
2/	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	s a consequence of):								
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XOD	death certificate e attending phys od for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Da	ate of delive	v	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No			Ectopic pregnan Other (specify)	cy			М	onth	Day Yea	г
л Э	res that the de igned by the a be detached f	Phy	9 Unknown										
ds,	requires that the	d by	Part ff. Other significant condition Depression	is contributing to death i	out not resulting in the ui	nderlying cause g	jiven in Part I.	•				e cause of deat obly 4 ⊡Unkr	
ecords,		Completed	Malnutrition					_					
ř	has has	duic	nainatitition						24a. Was an autopsy performed	1?	prior to com death?	sy findings ava apletion of caus	e of
Vitai K	icien: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of		Yes 25	No	1 ☐ Yes	2 □ No	
o	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpati	ent 2 ER/Outpatien	t 3□ DOA O	ab		5 🗆 Residence	e 6 □Otl	her (Specify)	)	
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UNISION	death death ctor: y the	ficat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	ot be 280 Place of In	jury - At home, farm, str		]Yes 2∐No		ocation (Stree	t and Num	her or Rural	Route Number,	
2	el or A s after I Dire d in b	Certification:	4 Homicide determin	building, e	tc. (Specify)	sor, ractory, office	,	201. 6	City or Town, S	tate)	Del of Hulai	HODIO / VOITIDO/,	
	To the Hospitel or Attending Physicien: Within 24 hours after deals.  To the Funerel Director. After this certific completely filled in by the funeral director,		29a. Certifier  (Check only 2 ☐ Medical E	Physician: To the best	of my knowledge, death of examination and/or inv	occurred at the	time, date and p	place, and d	ue to the caus	e(s) and m	anner as sta	ted.	
	the H hin 24 the F	Medical	one)	and manner si	lated.			occumed at					
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	X	ŀ	30. Name and address of person w				9284		F	ebrua	ry 26	, 2004	
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 06868 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** JLORIA PRICE February 29. 2004 9:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Creater Baltimore Medical Center Towson
If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 25 F 215.42.5685 59 MARYLAND Director 4 UNE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at BALTIMORE 1 ☐ Yes 2 No MARYLAND BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or 212360 MOPEC S Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No  $\mathcal{F}_{ICC}$   $\mathcal{E}_{ICC}$  Baltimore, Maryland 21215-0036 Specify: WHITE þ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "ne any injury or other traumetic event, the Medic once. JOVERNMENT Elementary/Secondary (0-12) College (1-4or 5+) ECRETARY HUMAN RESOURCES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RICE ILDRED ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUN, P ALTIMORE, MD ALMA EISENHARDT Date 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cametery, crematory or other place) 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State MARCH 2,2004 FOREST HILL \* 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND AIR 21. Signature of Funeral Service License 22. Name and Address of Facility EVANS FUNDRAL CHAPPEL RD, PARKVILLE, MD 21234 SECO HARFURD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bilateral bronchopneumonia hours/days /Medical Due to (or as a consequence of). Examiner Severe esophagitis Sequentially list conditions, flary, leading to in reclaid cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last months Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 0 9 Unknown 9 Hinknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Crohn's disease 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Pulmonary emphysema 24a. Was an autopsy performed? 1 Yes 2 🗆 No Diabetes mellitus or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐¶npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. Director: A I in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lan D30206 March 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N 3. Registrar's Signature Steven H. Pearlman, 6701 N. Charles St., Towson MD 21204 31. Date filed (Month Day, 5 2004 State Registrar

For Amend Items 25,27,28abcder per MF,C829,03/04/04dhb Registrar Amend Item 1 per ME,C829,03/05/04dbertificate of Death Reg. No. 06869 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LINDA PEDERSEN 7, 2004 /Medical 4e. Facility-Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MOKE N/ASUMOS as | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MAY 20, 1950 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (Stete or Foreign Country) **Funeral** 1 □ M 2X F 217-56-7875 53 Director MARYLAND Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 XYes 2 ☐ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 240 S. CHAPEL STREET or Items 23e 21231 by Funerai U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed with nent of Health and Mental Hygiene. ent: If Item 27 Is marked other than ury or other traumatic event, tha M HOUSEKEEPING JOHNS HOPKINS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES TRENT, SR. ၉ MARGARET WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL PEDERSEN/ HUSBAND 240 S. CHAPEL STREET, BALTIMORE, MD. 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or OAK LAWN CEMETERY 1/23/04 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LILLY & ZEILER INC. once. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEMATOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnant 15 Other (specify) in the past 12 months? Month Day Year P.0. 1 ☐ Yes 2 Ū No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 3 Probably 4 ⊠Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Tes 2 1 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Certification: To Other 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) (his 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Pending death. Unknown investigation Unknown 1 ☐ Yes 2 📉 No 2 XAccident the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*HOSPITAL 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Johns Hopkins Hospital, Balto., MD Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Doctor Medical 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ames CastleMD600 Wolfe 31. Date filed (Month, Day, Year) MAR 0 4 2004 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygien 06870 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Voar February **Physician** H. Patel 7:50 p.m Nischal 28 2004 /Medical 4c. County of Deeth 4e. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner 801 Faraway Court Bowie Prince Georges Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 11/8/1972 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 31 Yrs. Africa 589-11-0146 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 28a-f show item 27 ie marked other then "natural", or items 23a or 28a-f shov other traumatic event, the Modical Exempler must be notified at 1 □X/es 2 □ No Prince Georges Director MD Bowie 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20721 801 Faraway Court 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "natural; or item eny injury or other traumatic event, the Modical Exercit 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No altimore, Maryland 21215-0036 Specify Specify: Asian 2 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Industry 12 Program Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sitaben Patel Hasmukhlal Patel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Faraway Court, Bowie, Maryland 20721 Manjula Patel / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Balt./Wash. Crematory 3/2/2004 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home, Inc. M01338 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal tailure 10 days **Physician** /Medical Due to (or as a consequence of): **Examiner** Cholangi weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Colorectal Cancer The law requires that the death certificate be executed physician and s the burial-transit Metastatic Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai attending pt for use as tl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð bowel Obstruction 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed? 1 Yes 2 No rector, page 2 2**X** No 1 Tyes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur d title of certifier March 2004 M,D. cause of death (Item 23a) (Type, Print) 30. Name and address of person who co Samue religh 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

				State of Marylan	d / Depa	artmer		nd Mental Hy	aiene	04 06871	
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last)     Jeanette Gloria Pa     4a. Fecility Name (If not institution, give si     Franklin Woods Nurs	treet and number)			, Town, or Location of Rosedale	2. Date of De Month March	3, 20 4c. County	year 004 3. Time of Death 10:25 P M of Death timore	
	Funeral Director		Social Security Number		last birthday) Yrs.		r 1 Year   If Under 24	Min. 8. Date of Bir (Month, De Dec • 29		9. Birthplace (State or Foreign Country) New York	7
	death with the Maryland me 23a or 28a-f show	ctor	10a. State 10b. County  Maryland Baltimore		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 200 No	
	23a or 2	Funeral Director	10e. Street and Number 2217 Monocacy Rd.				p Code 21221		10g. Citizen of V USA	•	
036	72 hours after death with the Marylar Fratural; or theme 23a or 28a-1 show Ideal Examiner can be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1  Yes	dent of Hispanic Origi ocity Cuban, Mexican, 2⊠ No Specity:	n? (Specify Yes or No Puerto Rican, etc.)	Blac	e - American Indian, ck, While, etc. White	
9500-61212	within ene. than	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	denl's Usi kind of wi DO NOT I	ual Occupation ork done during most of use retired)	of working	16b. Kind of Bu	usiness/Industry	
	B E B B	To Be C	17. Father's Name (First, Middle, Last) William Downing		,			s Name (First, Middle Se Meir	, Maiden Surnam	ne)	
	and 2 should lealth and Meni m 27 is marke her treumatic		19a. Informant's Name/Relationship (Type Kathleen Anderson	·		-	s (Street and Number cent Rd. Wh				
e e	-+95		20a. Method of Disposition  1 XBurial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	emoval from State	Place of Disponentery, crei	matory or	other place)	3/6/2004		City or Town, State re, Maryland	
Baltir	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service License		B	2. Name a	nd Address of Facility Zinski Fund Old Easterr	eral Home :	P.A.		
	death certificate be executed e attending physician and and and tor use as the burial-transit	dical Examiner	23a Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a conse	uence of):		de of dying, such as co diomyo	pothy	Frest,	Approximate Interval Batween Onset and Death	
O. Box 6	Q 0 Q	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Selo 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	⊒Ectopic p ∃Other (s			23d. Dat Mor	te of delivery nth Day Year	
rds, P.	The law requires that the de ite has been signed by the bage 2 should be detached	d by Pr	Part II. Other significant conditions con	•	ulting in the u	nderlying	cause given in Part I.			ribute to the cause of death?	ı
	The larate has	Completed by							psy prmed? d 2 200 1	Were autopsy findings available prior to completion of cause of death?	,
× Vit	Phyelcien: Th this certificate al director, pag	To Be	T Tes Aprio	ospital: 1  Inpatient 2			OA Other: 4 Urs	of Death (Check only sing Home 5 Res	dence 6 Othe		
Division of	or Attending Patter death. Diractor: After in by the funera	atlon:	27. Manner of D ath  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		how injury occurr	ed	
N N	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif			0,52	City or To	wn, State)	er or Rural Route Number,	
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	29a. Certifier Certifying Phys (Check only one)	sician: To the best of my kno ter: On the basis of examina and manner stated.	owledge, deat ition and/or in	h occurred vestigation	d at the time, date and n, in my opinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)	
•	Within To t	×	29b. Signature and tive of certifier	_ m	>	29	D534	62	29d. Date signed 3/4	d (Month, Day, Year)	
	13		30. Name and address of person who con							ons am sing	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 0 5 2004	32. Registrar's Signa	Miro	pork		DC SIE	11 1W(1)	ine inin cios	1

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State of Maryland / Department of Health and Mental Hygiena

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	Physiciar		ent's Name (First, M	iddle, Las	t)						2. Date of D	eath	ay	Year	3. Time	of Death
	/Medica	Ja	cqueline	Robi	11ard						March	3	2	2004	20:2	0
	Examine	4a Facility	y Name (If not institu	ution, give	street and num	iber)				4b. City, Town, or			c. County			
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	Funeral Director	230-3	30-3297		DM 2只F	7. Age (in yr.	s. last birthda Yrs.	Month		Hours Min		Day, Year 2 19:	") 31	9. Birthp Coun Ohi	lace (State try) O	or Forei <b>g</b> n
	and #	10a. State				10c. (	City, Town or	Location						1	0d. Inside	City Limits
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	after death with the Mar w flems 23s or 28s-f sinher must be notitified	10e. Stree 3921	ot and Number 01d West	t Fal	ls Road			10f. 2	Zip Code 217	71		10g. C		What Coun	try?	
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an	Mental H Mental H Irked ott		cois Dulo							Lucia F		-,o		,		
a7	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, tre March To Re Comp.	19a. Infor	mant's Name/Relati	onship (T)	ype, Print)		19b. Mai	ling Addre	ss (Street	and Number or R	ural Route Numi	ber, City	or Town,	State, Zip	Code)	
Z	and 2 paith a	Edwa	rd Charle	∍s Ro	billard	(spot	ıse) 39	921 0	1d We	est Falls	Rd., M	t. A	iry,	Md 2	21771	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is mericed other than any injury or other traumatic event, trainings.	1 🔯 B	od of Disposition urial 2 Cremation onation 5 Other			tate Ga	Place of Disp cemetery, cr arrisor	position (Nematory of Por	lame of rotherpla est V	eterans	Date 3-9-04			City or To		
Balt	permit. Departimporti	21. Signat	ture of Funeral Servi	ice Licens	Herber	ct	ŀ	22. Name	and Addre	ss of Facility Ha 95 Sykes	ight Fu	nera Md 2	1 Ho	me &	Chape	el
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N	Physician /Medical	Immediate	Cause (Final		,	UNO	_			er					Onset and	d Death
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n C	After funer	27. Manner	tural 5 ☐ Pen	iding	28a. Date of (Month,	njury , Day Year)	28b. Time ( Injury	of M	28c. Injur Wor	yat k? Yes 2 □ No	28d. Describe	how inju	ry occurre	ed		
Division	tal or Attanding Programmers after death.  al Director: After to add in by the funers  Certification:	2 □ Ac 3 □ St 4 □ Hc	icide 6 ☐ Cou	estigation uld not be ermined		of Injury - At h g, etc. <i>(Speci</i>	nome, farm, s			163 2 100	28f. Location ( City or To			er or Rural	Route Nu	mber,
	To the Hospital or Attanding Phymin 24 hours aftar death.  To the Funeral Director: After thi completaly filled in by the funeral Medical Certification: 1	29a. Certif (Checi	ier 1. Certif k only 2 Madic	ying Phy∉ ai Examlı	sician: To the bener: On the bas and manne	is of examina	owledge, dea ation and/or ir	th occurre	d at the tin	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s date and	) and mar d place, a	nner as sta and due to	ited. the cause	(s)
	within To the comple	29b. Signa	ture and title of certi	ifier	1.5	1		2	9c. Licens	e number		29d. Da	ite signed	Month, D	ay, Year)	
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and a	(1	30. Name a	and address of person	on who ca	mpleted cause	of death (Ite	m 23a) (Type	, Print)	00				11			. 1
-	4	20	seph 1	Mo	HAG	IERT)	/ m	D	410	) ( n	redical	CH	RI	DR K	ckkri	lle Mi)
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Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2004 06874 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year February 29, 2004 **Physician** TTALIATA LUGENE 01:07p.nM ANIEL /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Days Hours Min Director 213-32-2389 6 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Iteme 23a or 28a-1 ebov treumatic event, the Mudical Experimer must be notified at 1 ☐ Yes 2 No Completed by Funeral Director MARYLAND BALTIMORE KOSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7901 DALROSE 2123 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes. Give Year or Dates: 195 3 195 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is 1 and 2 should be filed within 7 if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BRAKEMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ASPER FRANKLIN KETTALLATA TOLDIE ဥ 19a. Informant's Name/Relationship (Type, Print) WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RETTALIATA 7301 ALTIMORE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it eny injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HARKWOOD \* 4 □ Donation 5 □ Other (Spelayly) EMETERY MARCH (0. 2004 PARKVIL 21. Sign fun at Fun ra Savice Libensee 22. Name and Address of Facility EVANS FUNERAL CHAPEL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary FIBRASIS **Physician** disease or condition resulting in death) 3 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ng physician and as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl. one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Image: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

[Image: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO043489 2/29/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ni Charles St. 54 601 Balt MP 21212 BOHATER M 6569 31. Date filed (Mon Mar RY (9r) 5 2004 32. Flagistrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Sandra Jean Ryan 29, 2004 February /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 10449 Sweepstakes Road Damascus Montgomery 8. Date of Birth (Month, Day, Year) May 31, 1946 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 1 F 57 220-40-2806 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland | Montgomery Damascus 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10449 Sweepstakes Road 20872 United States death v Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 212 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) U.S. Government Elementary/Secondary (0-12) College (1-4or 5+) d Hygiene. Dept. of Commerce Budget Analyst permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked othe any Injury or other traumatic event 2016. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Reid Winifred Grace Lane ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10449 Sweepstakes Road, Damascus, Maryland 20872 Lawrence Edward Ryan/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition March 5, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery 2004 Germantown, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850-2805 21. Signature of Funeral Service Licensee M00198 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) MELANONA **Physician** MALIGNANT & MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and hed for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4□Pregnant at time of death 5 Other (specify) detached 9□ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy performed?

1 Yes 2 No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes No Medical Certification: To 3 DOA this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. м investigation 2 Accident the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 9 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only ŝ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier elle 145014 2004 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLANDWOOD COURT #111 OLMY 170 20832 ISABELLA VARTIRE 20 3418 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death		_ 211114	06876
	Physici	an	Decedent's Name (First, Middle, La.	· · · · · · · · · · · · · · · · · · ·	A	2. Date of Death Month	Day Yeer	3. Time of Death
}	/Medic	al	4e. Facility Name of not institution, giv.	e street and number)	4b. City, Town, or Location of Deat	march 1	4c. County of Death	>1×11-M
			3 Brooking Ct	;	Timonium	1	Baltin	nore Co.
k.	Funeral Director		5. Social Security Number 0 6. S  215-07-5790 1  Usuel Residence of Decedent	ex 7. Age (In yrs. last birthda) Yrs.	// If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp Coun 1919 Ma	lece (State or Foreign try)
	death with the Maryland rms 23s or 28s-f show f must be indiffed at	tor	Maryland Batti	mare Co. Tim	onium		1	0d. Inside City Limits
	h with the	il Director	10e. Street and Number  3 Rooking	Ct.	10f. Zip Code 21093	10g.	Citizen of What Coun	try?
36	be fited within 72 hours after death with the Marylan ital Hygiene. Indoorber then "naturel", or items 23e or 28e-f show event, it a Medical Exant and mant be indiffed at	by Funeral	11. Marital Status  1 Never Married 2 Married	1 ☐ Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen 1 Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	within 72 hours after bne. than "natural", or Ite ta Medical Evanton	Completed b	3 Widowed 4 □ Divorced  15. Decedent's Ec (Specify only highest gra	de completed) (Giv	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	rking 16b	b. Kind of Business/Inc	lustry
212	filed withi Hygiene. other ther	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	Home Mak	er	Oun Ho	ome
Maryland	should be file nd Mental Hy marked oth amatic event	To Be (	Patrick J.	McDonough, S	18. Mother's Nar	ne (First, Middle, Maio	den Sumame)	
	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		19a, Informant's Name/Relationship (Mr. Marc E	- Stoddard 106	ling Address Street and Number or Au	Lane A	ty or Town, State, Zip	code) exsuille, MD,
<b>Baltimore</b> ,	Pa nnen ury		20a. Method of Disposition  1	memoval from State	nosition (Name of ormatory or other place)  ARM (Chapel-BelAN)	-3-2004 20c	Location - City or To	wn, State
Balt	permit. Pag Department Important: any injury o		21. Signature of Euneral Service Licer	gan, Is.	2. Name any Address of Agrilly CACE	pativest	ineral +C	remation (+1
	Pnysician		23a. Part V. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	nications that caused the death. Do not er one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a.  Due to (or as a conseq tence of):	000000000000000000000000000000000000000	1		
	outed ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as a consequence of):				
Вох 68	death certifica e attending ph od for use as th	//Wed	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deliver	· · · · · · · · · · · · · · · · · · ·
o	0 0 0	by Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)			Day Year
rds, P	w requires that been signed k should be deta	ed by PI	Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	
Division of Vital Records,	2 2 2	Completed				24a. Was an autopsy performed 1 Yes 2	prior to com	sy findings available spletion of cause of
Vita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hoositali		th (Check only one)		
of	Phyeir this crat dir	2	1 ☐ Yes 2 No  27. Manger of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie  28a. Date of Injury 28b. Time (		ome 5 Residence		)
IO	ittending death. ctor: After / the fune	ation	1 Anaturel 5 Pending 2 Accident investigation	(Month, Day Year) Injury	of 28c. Injury at Work?  M 1 Tyes 2 No	200. Describe flow if	ijury occurred	
Divis	or A fter Jire in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
	To the Hospital within 24 hours a To the Funeral is completely filled	Medical (	29a. Certifier (Check only one)	ysician: To the best of my knowledge, dea niner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the cause rred at the time, date a	o(s) and manner as sta and place, and due to	ited. the cause(s)
)	To t	Σ	29b. Signatur-, and title of certifier	Melholum	29c. Icense number	29d. [	Date signed (Month, D	ay, Year)
1	5		30. Name and address of person who	completed cause of geath (Item 23a) (Type	. Print)	m.0 2.1	792	11 10 110
	Sta		31. Date filed (Month, Day, Year)	32. Hegistrar's Signature	Lack a	TILL CI		

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 2,2004 Year **Physician** 4:45 A M Synodinos Anna /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK if Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 212.14.923 Days Hours Min 1 ☐ M 2 🔀 F March 24, 1920 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28e-f show the Medical Examiner must be notified at BALTIMORE PERRY HALL 1 ☐ Yes 2 KNo MARYLAND Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or #9D SA ACE 212360 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS OUNTRY Pages 1 and 2 should be filled witnest of Health and Mental Hygien tent: If Item 27 is marked other theury or other treumatic event, Ital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be URZ WILLIAM ARIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21703 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Description of the place of Disposition (Name of Cemetery, crematory or other place)

MEMORIAL GAR DEUS MARCH 5, 2004 KOBERT COURT, FREDERICK, MD l HOMPSON 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. TIMONIUM, 4 Donation 5 Other (Specify) 22. Name and Address of Facility EVANS FUNERAL CHAPEL 21. Signature of Funeral Service License 8800 HARFORD RD, PARKVILLE, MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Edema Yulmonary 1814 **Physician** /Medical Due to (or as a consequence of): 121W Examiner Atelectasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran the attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year ō Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. þ should be Ken 1 Yes 2 □ No 3 ☐ Probably 4 ☐Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 certificate 1 ☐ Yes 2 No uneral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: Al
completely filled in by the fu investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide To the Hospital 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie pleted cause of death (Item 23a) (Type, Print) 30. Name applied address of person who complete and Zandi TOLL HOUSE AVE 32 Registrar's Signature 31. Date filed (Md) A. Day (Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LAWZ FIBRUARY 23 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ROPIUEL SV 1200st If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min TAM 2 F Yrs. 10 716 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or items 23a 21234 OURI death Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If tem 27 is marked other the any injury or other traum... 12. Was Decedent Ever in U.S. Armed Forces? 11€ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: W. W.III 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced THEW Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) 127KZ IZACHER OF BALLIFOR 17. Father's Name (First, Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) OSWALO KATH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 456is BRYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 20000 4 □ Donation 5 □ Other (Specify) DULACKY VALLEY 400L 21. Sign Jure of Funer II Shrvice Litensee 22. Name and Address of Facility ( 13.0 ROSO Ano alas4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** WH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 11811 Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a P.O. Box 68760 Physician/Medical as attending f IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death Day 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ been si 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b lirector, page 2 si 24a. Was an autopsy performed? Division of Vital 1 Yes 2 No director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: Medical Certification: To 1 ☐ Yes 25 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide ₩© Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier c.mpletely (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Marth Pay 6ar) 32 egistrar's Signature State 2004 Registrar

State of Maryland / Department of Health at Certificate of Death  1. Decedent's Name (First, Middle, Last)  Ruby Scott  4a. Facility Name (If not institution, give street and number)  800 Parrot Court  5. Social Security Number 6. Sex 1 Months Days Hours  5. Social Security Number 6. Sex 1 Months Days Hours  5. Social Security Number 6. Sex 1 Months Days Hours  5. Social Security Number 6. Sex 1 Months Days Hours  7. Age (In yrs. last birthday) If Under 1 Year of Hours Days Hours  10a. State 10b. County 10c. City, Town or Location  MD Prince George's Landover  10b. Street and Number 10c. City, Town or Location  11 Marital Status 1 Never Married 2 Married 3 Months Days Hours 1 Never Married 2 Married 1 Never Married 2 Married 3 Months Days Hours 1 Never Married 2 Married 1 Never Married 2 Married 3 Months Days Hours 1 Never Married 2 Married 1 Never Married 2 Married 3 Months Days Hours 1 Never Married 2 Married 1 Never Married 2 Married 3 Months Days Hours 1 Never Married 2 Married 1 Never Married 2 Married 3 Months Days Hours 1 Never Married 2 Married 1 Never Married 2 Married 3 Months Days Hours 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 3 Months Days Hours 1 Never Married 2 Married 1 Never Married 2 N	2. Date of Dea Month 03  Death  4 Hrs. 8. Date of Birt (Month, Da) 09 05	Day Year 02 2004  4c. County of Death Prince Ge h, Year) 17 Fupe1  10g. Citizen of What Coun	3. Time of Death  9:32 A M  Orge's  lace (State or Foreign nity)  O. MS.  O. MS.  O. MS.  O. MS.  Only Yes 2 No
800 Parrot Court    Social Security Number   6. Sex   1	4 Hrs. 8. Date of Birt Min. (Month, Da) 09 05	Prince Ge  Prince Ge  9. Birthn Cour  17 Fupe1  10g. Citizen of What Cour  USA  14. Race - Americ Black, White,	olace (State or Foreign only)  O. MS.  Od. Inside City Limits  **[Yes 2   No only)  only?  can Indian,
Usual Residence of Decedent  10a. State  10b. County  MD  Prince George's  Landover  10c. City, Town or Location  Landover  10c. Street and Number  10c. Street and Number  20785		10g. Citizen of What Cour  USA  14. Race - Americ Black, White,	10d. Inside City Limits  12 Yes 2 No  ntry?  can Indian,
106. Street and Number 107. Zip Code 800 Parrot Court 20785		USA 14. Race - Americ Black, White,	can Indian,
11. Marital Status  1 Never Married 2 Married  1 Never Married 3 Married  3 Midowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, II Yes 2 No If Yes, Give Year or Dates:  1 Yes 2 No Specify:			
The state of marked		Hospita1  Maiden Sumame)	dustry
Eddie Griffin, Sr.  Figure 19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  Cheryl Wiggs Daughter  800 Parrot Ct. LAnde			Code)
20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   1 弦Burial 2 □ Cremation 3 □ Removal from State   1 弦Burial 2 □ Cremation 5 □ Other (Specify)   Harmony Memorial Park			
23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as call shock, or heart failure. List only one cause on each line.	.W. Washing	gton, D.C. 2	
Immediate Cause (Final disease or condition resulting in death)    Due to (or as a consequence of):			3 morths
So stated to be seen t		23d. Date of delive Month	ory Day Year
\$ 5 5 6 2 4 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.		obacco use contribute to th	ne cause of death? ably 4 □Unknown
The range of the r	24a. Was a autop: perfor. 1 Yes	sy prior to con med? death? 2₺No 1☐Yes	psy findings available npletion of cause of
5 5 5 7 Manner of Death 28a Date of Injury 28b Time of 28c Injury at	ing Home 5 AResid	ence 6 Other (Specify ow injury occurred	)
O e a a a a a a a a a a a a a a a a a a	City or Town		
Consider the stress of the second of the sec	occurred at the time, d	ause(s) and manner as state and place, and due to	the cause(s)
Marcy D. Henry M. Doo 409	04	3/3/20	204
State Registrar  State Registrar	E., HYAT	TSVILLE, N	D 2078

۲			1 - For State Registrar	te of Maryland	/ Depa	artment of trificate of	Health ar Death	nd Mental Hyg	giene 2 (	004	06880
	Physici /Medic		Decedent's Name (First, Middle, Last)     Olivia	Sui				2. Date of Dea Februar		2004	3. Time of Death 1905 M
	Examir		4a. Facility Name (If not institution, give street a Good Samaritan Hospital  5. Social Security Number 6. Sex	nd number)  7. Age (In yrs. las.	e histodovil	4b. City, Town, Baltimo	re		N/A		(2)
	Funeral Director		214-22-6761 1 M 25		Yrs.	Months Days		Min. 8. Date of Birtl Month, Day May 25,	1925	9. Birthol Coun Mary 1	ace (State or Foreign try) and
	Ne Marylan 8a-f show	Director	10a. State 10b. County  Maryland N/A	10c. City, 1 Ba	own or Lo Itimor	e				10	0d. Inside City Limits 1) Yes 2 ☐ No
	ath with II	ral Dire	10e. Street and Number 2707 Halcyon Avenue			10f. Zip Code 21214			10g. Citizen of USA	What Coun	try?
980	72 hours after death with the Maryland hatural, or items 23a or 28a-f show disal Examinal mual be notified at	by Funeral	1 Never Married 2 Married 1 If You	s Decedent Ever in U.S. ed Forces? Yes 2 X No es, Give r or Dates:	1	Vas Decedent of Yes, specify Cub		? (Specify Yes or No- Puerto Rican, etc.)	Bla	ice - America ack, White, e	etc.
Maryland 21215-0036	d within 72 happene.	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)  Coll	ege (1-4or 5+)	(Give life. [	ent's Usual Occu kind of work done OO NOT use retire	during most of	f working	16b. Kind of E		ustry
/land	2 should be filed and Mental Hyg Is marked othe aumatic event,	To Be C	17. Father's Name (First, Middle, Last) Doo Wing Quock				18. Mother's	Name (First, Middle,			
Man	od 2 sho Ith and I 27 is me		19a. Informant's Name/Relationship (Type, Print) Damon D. Sui-Son	t)				r Rural Route Number	-		Code)
Baltimore, I	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal  4 Donation 5 Other (Specify)	from State ceme	e of Dispos etery, crem	sition (Name of latory or other pla letory or other pla ley Mem. (	ce)		yland 2 20c. Location Timonium		
Balti	permit. Departn Imports any inju		Chustina J. Will	ristina L. Hil	ton <sup>22</sup> 5	Name and Addre eopard J 305 Harfor	ess of Facility Ruck In a Road	Båltimore Mar	yland 2	21214	
8760,	Physician / Medical Examiner sthe private street is the private street in the private st	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	that caused the death. If a on each line.  Let to (or as a consequent to (or as a consequen	ce of):	ir the mode of dyi	VVES.	Idiac or respiratory arm		i	Approximate Interval Between Onset and Death
P.O. Box 687	The law requires that the death certificate be executed as bear signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	s, outcome of pregnancy Live birth 2 ☐ Fetal de. Pregnant at time of death Unknown	ath 3 🗌	Ectopic pregnancy Other (specify)	<i>y</i>			ate of deliver	y Day Year
	quires that in signed by uld be deta	by	Part II. Other significant conditions contributing	to death but not resultin	g in the un	derlying cause giv	ren in Part I.		pacco use contes 2 No		cause of death?
I Reco		Completed						24a. Was a autops perforn 1 \( \text{Yes} \) 2	y ned?	Were autops prior to com death? 1  Yes 2	sy findings available pletion of cause of
Division of Vital Records,	I or Attending Physicien: The latter death. Director: After this certificate he in by the funeral director, page	Certification: To Be	2 Accident investigation 3 Suicide 6 Could not be determined 28e.		Outpatient  Time of Injury  farm, stre	28c. Injur Wor M 1 🗆	er: 4 🗆 Nursin	Death (Check only only only only only only only only	nce 6 Oth	red	Route Number,
Ω	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical Cer	29a. Certifier (Check Only one)  2 Medical Examiner: On and	the basis of examination	ige, death and/or inve	occurred at the tirestigation, in my o	ne, date and pl pinion, death o	ace and due to the ca	use s and ma	anner as stat	ed. he cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	manner stated.	10	29c. Licens		29	od. Date signed	d (Month, Da	ay, Year)
	8		30. Name and address of person who completed Jerold Ensel, MD 560			rint)			1239	100	
¥.	Sta Registra	te ar	31. Date filed MARDay: 32004	1 Loch Rave	Sheet	C JOUL	Darcin	ore, MD Z.	1233		

State of Maryland / Department of Health and Mental Hygiene For State RegistracAMEND ITEM #7 PER FH G829 3/05/04 JICertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year Month SHERONA 2004 /Medical 4a. Facility Name (If not institution, give street and 4c. County of Death Examiner 4859 Bowland 5. Social Security Number 6. Sex 1timos e If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 M 39 Yrs. Director 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show 10d. Inside City Limits other treumstic event, It a Medical Examiner must be notified at 1 FYes 2 No Completed by Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 4859 AVE USA 21206 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Ves Give 1 ☐ Yes 2 ☐ No Specify: Specify: 13/90 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than ury or other treumstic event, It a Me Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12th Bookeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Deluces ပ NHOL Mashal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Street spouse 4859 Bow

20b. Place of Disposition (Name of cemetery, crematory or other place) Dennis land Ave Balto. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or Grownsville VA Cen. 3-4-04 4 ☐ Donation 5 ☐ Other (Specify) rown sv: He MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jr. Fun eral Home 2009 Eastern Ave 139 Ho Md. 21231 Part 1. Enter the disease shock, or heart failure. e, or complications that List only one cause in d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death each Immediate Cause (Final disease or condition resulting in death) **Physician** לדר א שום Cuncer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): the attending physicien Box 68760, Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by should ! Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) has l autopsy performe page certificate 1 ☐ Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home Medical Certification: To 1 Inpatient 2 ER/Outpatient this 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pendina death. investigation 2 🗌 No after death Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 40854 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kusebers 301 St- Paul P) 21205 NV 31. Date filed Manth. State . Registrar's Signature Grand Registrar

DHMH 17 Rev 1/2001

10	OPIL/	For		se Type or State	of Ma	aryland	/ Depa	rtment of	Healt	h and N				4 06882	7
Physic		Decedent's Nam		em#Z3a,Part	: П,	27,Per	ME,O&	201631491	D <b>ADg</b> a	th		Reg. No. ath Day	Year	3. Time of Death	
/Medi Examii		4a. Facility Name (	If not institution	, give street and n	number)			4b. City, Town			-	4c. PR	County of Dea	ath FGE's	
Funeral Director		5. Social Security N 220-02-7 Usual Residence of	387	6. Sex 1 M M 2 □ F	7. Ag	e (In yrs. Ias 35	st birthday) Yrs.	If Under 1 Yea Months Day		irs Min.	8. Date of Bir (Month, Da 10/6/1	th ly, Year) 968	9. Bi	rthplace (State or Foreign country) RYLAND	
show	or	10a. State	10b. County	DD			Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
with the Na or 28a-f	Funeral Director	10e. Street and Nu 9407 RIV	imber			LA	UKEL	10f. Zip Code 2072				10g. Citi	zen of What C	Country?	_
ite; Mal ylatid Z 1Z 13-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28a-1 show other traumatic event, the Madical Examinar must be notified at	by Funera	11. Marital Status	ried 2 Marr	12. Was De	Forces? 3 2 🔀 I Sive	Ever in U.S.	1	Was Decedent of I Yes, specify Co	f Hispanic Jban, Mex		pecify Yes or No Rican, etc.)		14. Race - Am Black, Wh Specify: W	ite, etc.	
hin 72 hou	Completed	(Spe		s Education t grade completed			16a. Deced (Give life, L	lent's Usual Occ kind of work dor DO NOT use reti	upation e during i red)	most of work	king	16b. Ki	nd ol Busines	s/Industry	
II yidlid ZiZi should be filed within d Mental Hygiene. marked other than matic event, ILEM	Ве Сош	12 17. Father's Name	(First, Middle,	(D)			CONS	TRUCTIO	18. M		ne (First, Middle	, Maiden		COMPANY	
2 should be and Ment	70	ROBERT  19a. Informant's N	lame/Relations	hip (Type, Print)				ng Address (Stre	et and Nu	ımber or Rui		er, City o			_
			sposition Cremation	3 □Removal from	m State	cen	ce of Dispo netery, cren	RIVERB sition (Name of natory or other p	lace)		Date	20c. Lo	cation - City o	r Town, State	_
Dattillor permit. Pages Department of Important: If it any injury or o		* 4 □ Donation 21. Signature of F			m	) FI.	22	LN CEME' Name and Add 601 SAN	tress of F	acility F	/2004 LECK FU ROAD. L	NERA	L HOME	, MARYLAND , INC. YLAND 20707	
Obvoision		shock, or he Immediate Cause	art failure. List (Final	complications that only one cause or Hyper	t caused each li	the death.	Do not ent		ying, such	n as cardiac	or respiratory a	-	.,	Approximate Interval Between Onset and Death	_
Physician /Medical Examiner	76	disease or condition resulting in death)  Sequentially list of any, leading to cause. Enter Und	)	Due t	o (or as	a conseque	ence of):								
wrequires that the death certificate be executed been signed by the attending physician and should be delached for use as the burial-transit	dicai Examiner	cause. Enter Und Cause (Disease o that initiated even resulting in death)	r injury ts	c. Due t	o (or as	a conseque	ince of):								
ords, F.C. BOX 0010 requires that the death certificate be signed by the attending physici nould be detached for use as the bu	by Physician/Medica	IF FEMALE: 23b. Was decede in the past 1: 1 □ Yes 2 9 □ Unknow	2 months?		e birth gnant a	of pregnance 2 Fetal d t time of dea	leath 3 🗆	Ectopic pregnal Other <i>(specify)</i>					23d. Date of de Month	elivery Day Year	
quires that nn signed t	ed by P			ons contributing to and Cocaine			-	nderlying cause	given in P	art I.		obacco u Yes 2[		to the cause of death?  Probably 4 Minknown	
The lay ate has page 2	Completed										24a. Was auto perfo	psy ormed?	prior to death?	autopsy lindings available completion of cause of s 2 \square No	
ysician: Tysician: Tysicia	o Be	25. Was case reference examiner?		Hospital: 1 (	Innatio	ant 2127 F	R/Outnatien	nt 3 DOA	)than		th (Check only only one 5 ☐ Resi		S COther (So	acity)	_
ਹ ਵੇਂ ਜ਼ੁਰੂ	-	27. Manner ol Dea 1 Natural 2 Accident		28a. Dai (Me		iry 2	28b. Time of Injury	28c. In	N. 180 P.		28d. Describe			Çünyi	5
LIVISIOR tel or Attending rs after death. al Director: After ed in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	inad 200. Fld	ice of Ini	ury - At hom c. (Specify)	ne, larm, str	eet, factory, office	e .		28l. Location ( City or To	Street an wn, State	d Number or F )	Rural Route Number,	
the Hospit in 24 hour the Funer pletely fills	Medical	29a. Certifier (Check only one)	2 A Medical			f examination		vestigation, in m	y opinion,	death occur		date and	place, and du	ue to the cause(s)	
To Toop	2	29b. Signature an	anes					C	ense numb	per			e signed ( <i>Mor</i> H 1,2004	nth, Day, Year)	_
				who completed ca	_	death (Item 2		Print) <b>1 Penn St</b>	reet,	Baltim	orre, Marry	land	21201		
Si Regis	ate	31. Date filed (Mo	0 5 200		. Registi	rar's Signatu	ire	bouls						1	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienes 06883 Certificate of Death 2. Date of Death 3. Time of Death. 1. Decedent's Name (First, Middle, Last) Yeer Month Sessanen **Physician** January Nellman 2004 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Bay view Wed Cto Johns Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 20, 1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**X** M 2□ F 84 220-03-2264 PA. Director Usuel Residence of Decedent lited within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other treumatic event, the Medical Examiner was be notified at 1 ☐ Yes 2 ☑ No Director Md Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 933 Dalton Avenue 21224 USA or Itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 years Steel Foreman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Wellman Sessamen Sr. Clara LaDuke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Sessamen Wife 933 Dalton Avenue, Dundalk, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 2004 10, 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) ō permit. Page Department of Important: If any injury or once. Sacred Heart Of Jesus Cem. Dundalk, MD. 21. Signature 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. tus 7110 Sollers Point ROad, Dundalk, MD. 21222 23a. Part. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** dans bdura /Medical Examiner 1-9 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ACOICAL EXAMINER use as the burial-transit that initiated events resulting in death) Last ION APPROVED Due to (or as a consequence of) CERTIFICA the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records. 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page . 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Alter 1 Natural 5 Pending December 21 2003 Found in PM 1 ☐ Yes 2 ☑ No death. tell down stairs investigation 2 Accident the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES 000 8 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Hoan 1 ran 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 0 4 2004 State Registrar

			For State	State of Marylar			Mental Hygie	ne2006	06884
			1 - State Registra MFND ITEM #17  1. Decedent's Name (First, Middle, Last,	PER FH G829 3/05	/04 JHertifica	ite of Death	Reg.	No.	3. Time of Death
	Physicia /Medic		William F	E. Se	lbv			Day Year > 29 2004	11:45 PM
	Examin		4a. Facility Name (If not institution, give	<b>N</b>	r D	y, Town, or Location of De	ath	4c. County of Death	
-	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.	last birthday) If Und	ler 1 Year If Under 24 H		9. Birthpl	ace (State or Foreign
-	Director		219-07-0310	M 2 F 8	Yrs. Month	s Days Hours M	n. Month, Bay, Ve	19 Ma	(ry)
	yland		Usuel Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Location		1-1	10	Od. Inside City Limits
	he Mar 8e-1 si	ector	MD		20_1time	ore			1 Des 2 No
	death with the Maryland ims 23a or 28e-f show		10e. Street and Number	MI ALIONIII	<b>o</b> )	2ip Code 2123	10g.	Citizen of What Count	try?
	r death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Agned Forces?	J.S. 13. Was Dec	edent of Hispanic Origin? Decify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - America Black, White, e	
36	72 hours after natural', or ite	by Fi	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 <b>07</b> Yes 2 □ No If Yes, Give Year or Dates:	_	2 No Specify:		Specify: Pula	cK
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121	e filed within all Hygiene. I other than ovant, the wes	ompl	Elementary/Secondary (0-12)	College (1-4or 5+)	DINING	Car Sun	ruicos 7	MAISON	notation
	be filed tal Hygid d other svant, II	Be C	17. Father's Name (First, Middle, Last)		J	18. Mother's N	ame (First, Middle, Maid	len Surname)	21-70-9
Maryland	2 should be and Mental is marked ( raumatic sv	၉	EDWARDS  19a. Informant's Name/Relationship (Ty		10h Mailing Addre	ss (Street and Number or	e JONE	ty or Town, State, Zil	Code)
Ma	5 <del>=</del> 2 ±		Shirley Clerr	y (Niece)	1537 L	Jin stow A	Ulvue R	ty or Town, State, Ziff (	11239
ore,	Pages 1 ar nent of Hea int: If itam iry or othe	. 5	20a. Mathod of Disposition 1 ☐ Berial 2 ☐ Cremation 3 ☐ R		Place of Disposition (N. cemetery, crematory or	ame of other place)	Date 20c.	. Location - City or Tov	wn, State
Baltimore	- 트립 등	-	<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>	Ga	misou to	est emetery	3/8/04 (1)	JINGS MI	ils, MO
Ba	Depa Impo eny is	U	Varto	Share	Van 498	ANG UNE	DA. Rold	MD 2	UICES I
			23a. Part1. Enter the disease or complished shock, or heart failure. List only or	cations that caused the deal	th. Do not enter the mo	ode of dying, such as card	ac or respiratory arrest,		Approximate Interval Between Onset and Death
f	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	Ce Nae	r with	mat		34 KS
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	ted nsit	Examiner	Sequentially list conditions, and laborate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	uence of):				
ó	cate be execu	Exa	that initiated events resulting in death) Last	Due to (or as a conseq	juence of):				
8760	icate be executed physician and s the burial-transit	dlcal		J.				455	
Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregna				23d. Date of deliver	у
.O. B	ne death the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c 9 ☐ Unknown				Month E	Day Year
٥.	res that the de signed by the a be detached f	y Phy	Part II. Other significant conditions cor	stributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?
Division of Vital Records,	The law requires ate has been sign page 2 should be	ted by					1 □ Yes	2)□No 3□Proba	bly 4 🗆 Unknown
3ec	e law r has be je 2 sh	Completed					24a, Was an autopsy	prior to com	sy findings available pletion of cause of
tal	an: Th ifficate or, pag		25. Was case referred to medical			26 Place of D	performed?  1 Yes 2 1 1		2 No
Š	hysicii his cert I direct	To Be	examiner?	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 0	O44	Home 5 Residence	6 □Other (Specify)	
ono	ding P h. After t funera	tlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Visi	Attand er death rector: / by the f	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, facto		28f. Location (Street City or Town, Sta	and Number or Rural i	Route Number,
ā	pital or A			<u> </u>			-1		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occurre tion and/or investigation	d at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated and place, and due to the control of the	ted. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	T	29	9c. License number	29d. E	Date signed (Month, Da	ay, Year)
		-	30 Name and address of	Suowi	n 22a) (Tuno Crist)	D 2714	7 3	11104	
	9		30. Name and address of person who co	w mo		Treene St	· Baltimo	ne mo	21201
	Sta Registra		31. Date filed (Month, Say, Year)	32 Registrar's Signa	ature		,		

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06885 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Daath 3. Time of Death Month Day 2004 **Physician** March 2, 7:15 A.M. Robert Hamilton Smith /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□ F Yrs. 1940 63 Dec. 14, Washington, D.C. Director 579-52-2045 Usual Rasidence of Dacedant Pages 1 and 2 should be filed within 72 hours efter death with the Meryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23s or 28s-f show any or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director |Maryland| Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5219 Wyoming Road 20816 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Race - American Indian, Black, White, atc. 11. Marital Status 1⊠Yes 2□No IfYas,Give Vietnam Year or Dates! 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 🗓 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Printing Manager Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be ٩ Walter Hamilton Smith Barbara Kraus 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a, Informant's Name/Relationship (Type, Print) Department of Health a important: If item 27 is any Injury or other trains Beth C. Smith/Wife 5219 Wyoming Road, Bethesda, Maryland 20816 20b. Place of Disposition (Name of March 2004 20a. Method of Disposition 20c. Location - City or Town, State Montgomery
Crematorium, Inc. 3, 1 ☐ Burial 2 【Cramation 3 ☐ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenu 21. Signature of Funeral Service Licens Wisconsin Avenue M01353 Bethesda, Maryland 20814 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Intarval Batwaan Onset and Death Physician Immediata Causa (Final disaase or condition resulting in daath) /Medicat a Metastatic Prostate Cancer Years Examiner Due to (or as a consequenca of): Physician/Medical Examiner anding physician end use as the buriel-trensit The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) P.O. Box 68760, that initiated events Dua to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? After this certificete hes been signed by funeral director, page 2 should be detected 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown þ Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy TLYS 2XING 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 KOther (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No edical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Panding invastigation 1 ☐ Yas 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 2 Accidant 6 Could not be datarmined 3 Suicide Location (Straet and Number or Rural Route Numbar, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital of within 24 hours er To the Funeral D Certifying Physician: To tha bast of my knowladga, daath occurred at tha time, data and place, and dua to tha causa(s) and manner as statad.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) 29a. Certifier (Check o and manner stated. 29b. Signati 29c. Licansa number 29d. Data signed (Month, Day, Year) D35635 March 2, 2004 30. Nama and address of pason who completed cause of daath (Itam 23a) (Type, Print) Joseph Kaplan, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 20855

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 5 2004

32. Ragistrar's Signature

State of Maryland / Department of Health and Mental Hygienes 06886 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARCH 2004 SALLY **SCHWARTZ** 10:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESENT & NURSING BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Days Hours 1 ☐ M 2 🛛 F 090-07-6050 Director 90 JAN. 12.1914 NEW YORK Usual Residence of Decedent the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas peptriment of Health and Mantal Hygiens. Insurati, or frems 23e or 28e-1 ehow Importants. It farm 27 is marked other than "natural; or frems 23e or 28e-1 ehow any injury or other traumatic event, the Medical Exercises must be reclifted. 1 ☐ Yes 2 ☑ No Director **OUEEN ANNE'S** GRASONVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 PROSPECT BAY DRIVE WEST 21638 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HYMAN FISHBERG EVA ၀ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 PROSPECT BAY DR. WEST, GRASONVILLE, MD 21638 CAROL COHEN DAUGHTER 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State ARLINGTON CHIZUK
AMUNO CONG.

22. Name and Address of Facility
22. Name and Address of Facility
25. Name and Address of Facility
26. Name and Address of Facility
27. Name and Address of Facility
28. Name and Address of Facility
29. Name and Address of Facility
20. 1 Burial 2 Cremation 3 Removal from State MAR.4,2004 BALTIMORE, MARYLAND ¹ 4 ☐Donation 5 Other (Specify) 21. Signature Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN RD. PIKESVILLE MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Dualto (or sels consequence of) The law requires that the death certificate be executed **burial-transit** Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 2 No 1 Tes 3 Probably 24a. Was an A4b. Were autopsy findings available prior to completion of cause of death?
 1 ☐ Yes 2 ☐ No page 2 1 ☐ Yes 2 17 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospited 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 1 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 0 5 2004

			1 - For Stete Registrar	State of Maryland / Depa	artment of Health and rtificate of Death		
	Dhysisi		Decedent's Name (First, Middle, La	st)	Timodio of Bodin	2. Date of Death Month	3. Time of Death
	Physici /Medio	al	Harry 1	homas		FEBRUARY	25, 2004 11:03 AM
	Examin	er	4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Deat	n .	4c. County of Death
(ess)	Funeral	~ a	5. Social Security Number 6. S	Sex 7. Age (In yrs. Jast birthday)			9. Birthplace (State or Foreign
	Director	0	15-80-7163 Usual Residence of Decedent	186M 2□F 42 Yrs.	Months Bayo Hours Man	12/22/	of Maryland
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	8a-1 s	ctor	MD	Balt	imore		1 <b>≛</b> Yes 2 No
	with ti	Dire	370 3 Ridge	COSTI Road	10f. Zip Code	10g.	Citizen of What Country?
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	specify Yes or No-	14. Race - American Indian, Black, White, etc.
36	72 hours after death with the Maryland natural; or Itema 23a or 28a-1 show alcal Examiner must be notified at	by Fu	Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 X No Specify:	to riteari, etc.)	Specify: Plack
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<b>Jan</b>	2 sho and I is ma	1	19a. Informant's Name/Relationship (		ng Address (Street and Number or Ri	ural Route Number, Cit	y or Town, State, Zip Code)
	Healti Healti tem 27		20a. Method of Disposition	SEN (Sister) 378	position (Name of Jace)	Date 20c.	Location - City or Town, State
E O	Pages nent of I ant: If Its ury or o		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Trailloval Irolli State	HILL Comptains	12/04 P	Atmon. MD
Baltimore	permit. Pages Deportment of Important: If I any njury or ance.		21. Signature of Funeral Service Lice	1500	Jame and Addres Facility	ene Fun	eral Solvices
	0 0 5 € 0		23a Part1 Foter the disease or com	plications that caused the death. Do not ent	4405 CORE	Rek · Eal	to MD 2/2/2.
	Physician	ļ li	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	or the mode or syring, —or as cardial	or respiratory arrest,	Interval Between Onset and Death
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b	Examiner	_	Sequentially list conditions,	b PNEUMONIA			
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9 XC	A _ U	n/Me	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery
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Vita Sita	siclan: certific	Be	25. Was case referred to medical examiner?	Hospital:	Other	ath Check only one	
of	ding Phys h. After this funeral di	n; To	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury (Month, Day Yeer)  28b. Time of Injury	11 3 DOA 4 Nursing F	ome 5 Residence 28d. Describe how in	
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Division of Vital Records,	l or At after d Direct I in by	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
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	o the tithin 24	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Day, Year)
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	0			completed cause of death (Item 23a) (Type,	Print)		
	Sta	te.	ELIAS ISSA MI 31. Date filed (Month, Day, Year)		JEN BLUD BAL	TIMORE, F	ID 21239
	Registr		MAR 0 5 20	V ,	home is		

-HOM Y, HARRY

UNK. 04-059

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State of Maryland / Department of Health and Mental Hygiene 2004

For State	State of Maryland
Registrar	

06888

			Registrar			Ce	rtificat	e of l	Jeath			Reg. No.	004	00000
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特別	Examir	- 40	4a. Facility Name (If not instituti 5100 block of				C	wing	Location JS Mi	lls			nty of Deatl	re
	Funeral Director		5. Social Security Number Unknown	6. Sex 1 □ M 2 □ F		n yrs. last birthday, 62 Yrs.	Months		If Under Hours	24 Hrs. Min.	8. Date of B	inh <b>2</b> 9, 194	9. Birthplace (State	
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4	or 28	Oire	10e. Street and Number				10f. Zip					10g. Citizen		untry?
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<b>1035</b> ours afte	rat', or it	þ	1 Never Married 2 Ma 3 Widowed 4 Divorce	arried 1 XYes If Yes, 0 ed Year or	3 2 □ No Give Dates:	Army	1 ☐ Yes	2[ <b>X</b> No	Specify:			Spe	city: Wh	ite
<b>1215</b> -within 72	lai hygiene. Id other than "natural", or liems 23a or 28a-f show event, I'm Medical Evantiner must be notified at	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education lest grade completed College	d) (1-4or 5+)	(Give	dent's Usua kind of wo DO NOT us Roofe	rk done d se retired	ation during mos	st of workir	ng	16b. Kind o	Business/I	
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Baltimore, permit. Pages 1 ar	Department of Heal Important: If item 2 any injury or other Once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other		m State	20b. Place of Disponentery, cre Wards Ch					ate 04	20c. Location		
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	y the attending physi ached for use as the l	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, of 1 Live 4 Pre	birth 2 [gnant at time	Fetal death 3	⊒Ectopic pr ⊒ Other (sp					1	Date of delin	very Day Year
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State

MAR 0 5 2004

Registrar

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	tem them	Funeral	11. Meritel Status		12. Was Decedent Armed Forces?		13. W	as Decedent of I Yes, specify Cub	Hispenic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-		American Ind White, etc.	ian,
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Baltimore, Maryland	permit. Peges 1 and 2 Department of Health s important: If Item 27 is any injury or other tre		21. Signature of Fu	neral Service Licen	3		R	Name and Addre	son Funer	al Home	, Inc			
				1/					Rd. Tow			04		
			23a. Pert1./Enter t shock, or hea	he disee∮e, ol⊷comp irt failure.' List only o	plications that caused one cause on each li	d the death. ne.	Do not enter	the mode of dyi	ng, such as cardia	c or respiratory	arrest,		Interv	oximate val Between it and Death
	Physician		Lucia d'ata Causa	(Fin - 1									1	t and Death
	/Medical Examiner		Immediate Cause disease or condition resulting in death)	(Final on	· PMI	NUM	0211	A					1	wk
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	hat the deby detac									1	Yes 2	□ No 3	☐ Probably	Unknown
tal Records,	signe signe	by							· · · · · · · · · · · · · · · · · · ·	240 18/0	s en autop		Ah Were au	topsy findings
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Division of V	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	286. Place of Inj	ury - At home c. <i>(Specify)</i>	e, farm, stree	et, factory, office		28f. Location City or To	(Street and wn, State)		or Rurei Rout	e <i>Number</i> ,
Ω	rel D	ပီ												
	To the Hospital or Attend within 24 hours after deet To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one)	1⊠ Certifying Phy 2  Medicai Exam	/sician: To the best of liner: On the basis of	f examinetion	dge, deeth on end/or inve	occurred at the tile estigation, in my o	me, date end place opinion, deeth occu	e, end due to the urred at the time	cause(s) , date end	and mann place, end	er as steted. I due to the c	ause(s)
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State of Maryland / Department of Health and Mental Hygiepe 06889

Year

BALTIMORE

2004

4c. County of Deeth

3. Time of Death

Birthplece (State or Foreign Country)

Country) Maryland

8:00 PM

Dete of Death Month

8. Date of Birth (Month, Day, Yee Sept. D1,

4b. City, Town, or Location of Deeth

TOW50N

If Under 24 Hrs.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Certificate of Death

If Under 1 Year

Deys

7. Age (In yrs. last birthday)

86

Yrs.

10c. City, Town or Location

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

518 CAMP MRADIR RUM LINITHIC

SITAVIERS JUIN 31. Dete filed (Month, Day, Year)

MAR 05

1. Decedent's Name (First, Middle, Last)

Stella

EDENWALD

5. Sociel Security Number

213-01-0515

Usuel Residence of Decedent

G.

4a Fecility Neme (If not institution, give street and number)

Taylor

1□ M 2 KF

**Physician** 

/Medical

Examiner

Funeral

Director

no. 32. Registrar's Signature

State

Registrar

		For State Registrar	State of M	aryland / [	Department of Certificate	of Health and of Death		giene 20	04 06890
Physicia /Medic		Decedent's Name (First, Middle, L     RAY MOND	, 1	1500			2. Date of Dea Month March	Day	Year 12:05A M
Examine Funeral Director	200	4a. Facility Name (If not institution, gr STELLA MARIS 5. Social Security Number 6. 213 - 32 - 0053	Hospic	e (In yrs. last bin	thday) If Under 1	wm, or Location of De Monton Year If Under 24 H Days Hours M	rs. 8. Date of Birth	4c. County	
DI &		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location			, , , , ,	10d. Inside City Limits
death with the Maryland me 23e or 28e-f show	ctor	MD BALT	imore		DUNDAL	_K			1 □ Yes 2 No
with the	Director	10e. Street and Number	0.03	٨	10f. Zip Co			10g. Citizen of W	*
IIIQ Z I Z I D-UUJO be filed within 72 hours after death with the Maryla tal Hygiene. d other than "natural", or lieme 23s or 28s-f show event, the Medical Examining must be multilied at	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Deceden	t of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		- American Indian,
72 hours after natural', or ite	۾	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Pres 2 I If Yes, Give Year or Dates:	MARINES	1 □ Yes _2□	No Specify:		Specify:	White
n 72 hours n 72 hours n "natural",	Completed	15. Decedent's E (Specify only highest gi	rade completed)		Decedent's Usual C (Give kind of work of life. DO NOT use i	tone during most of w	vorking	16b. Kind of Bu	siness/Industry
A I A I See and within "giene.  or than ", the Mer."	Comp	Elementary/Secondary (0-12)	College (1-4or	5+)	Mech	anic			ins corp.
hould be filed and Mental Hygin marked other matic event,	Be	17. Father's Name (First, Middle, Las				- mai	Beth Rich		9)
should be and Mental s marked (	2	19a. Informant's Name/Relationship		19b.	Mailing Address (S	treet and Number or			State, Zip Code)
E, N 1 and 2 1 eaith 9m 27 i	Į.	Shirley Wilso 20a. Method of Disposition	N (WIFE)	SUL Place of	Minha Disposition (Name		Balto. MO		
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DELLIMOTE, INIGITY CA permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumatic.	-	21. Signature of Funeral Service Lice	st, M.		22. Name and A	ddress of Facility	STELLA F	Funeral	Home CHTD.
CHUI		23a. Part . Enter the disease, or conshock, or heart failure. List only	nplications that caused one cause on each li	the death. Do r		f dying, such as card		1. 9	Approximate Interval Between
	al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of a consequence of a consequence of	of):				Onset and Death
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quires that quires that en signed b	2	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying caus	e given in Part I.			oute to the cause of death?
Physicien: The law requires certificate has been all director, page 2 should	Completed						24a. Was a autops perform	y pr ned? de	ere autopsy findings available for to completion of cause of tath?
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SICE OF COME OF SICE O	- 6	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Date	ry 28b. T		Injury at Work? 1 Yes 2 No	28d. Describe ho		
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le Hospil 24 hour le Funera Metely fille	Medical	29a. Certifier (Check only one)	hysician: To the best miner: On the basis of and manner sta		death occurred at the form investigation, in	ne time, date and pla- my opinion, death oc	ce, and due to the ca curred at the time, da	ause(s) and man ate and place, ar	ner as stated. Indicate to the cause(s)
To the within To the comp	Σ	29b. Signature and title of certifier	1.			cense number		9d. Date signed	(Month, Day, Year)
15	i	30. Name and address of person who			,,			7	
Stat	е	DR. TARIO MAHMO 31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	ALLEY RD.	TIMONTU	M, MD 2109	93	
Registra		MAR 0 5 2	004 Been	w B	portio	•			

12:05 а.ш.

2004

RAYMOND WILSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06891 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** VIRGINIA WRIGHT 18:10 Ph FEBRUARY /Medical 2004 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Locetion of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year 5. Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1□ M 25 F Hours 578-32-7859 Director 88 1915 Maryland 4, Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Locetion permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryiar Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or items 23s or 28s-f show with higher or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits Maryland Montgomery Germantown 1 ☐ Yes 2 反 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19531 Scenery Drive 20876 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) United States Administrative Assistant Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Monte Sanbower Grace Shry 19a. Informent's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Patsy W. Elder/Daughter 19531 Scenery Drive, Germantown, Maryland 20876 20b. Place of Disposition (Neme of cemetery, crematory or other place)
Clarksburg United Methodist March 4, Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clarksburg, Maryland 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Fuperal Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical PLEURAL EFFUSION DAYS Examiner Due to (or as a consequence of): Physician/Medical Examiner FEWDAYS PNEUMONIA use as the burial-transit Hospital or Attending Physician: The law requiras that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): attending physician and Division of Vital Records, P.O. Box 68760 ATRIAL FIBRILLATION Due to (or as a consequence of): resulting in death) Last cate has been signed by the a page 2 should be datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? ILLYUS ZANO 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1. □ Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Affer 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Discomplataly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) M·D FEBRUARY 2004 D0051158 29 V. Thertle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Ray 6/95

State

Registrar

VATTI.T. ANTHONY

MAR 0 5 2004

31. Date filed (Month, Day, Year)

M.0

2401

32 Registrar's Signature

RESEARCH

ROCKVILLE

BLUD#102

MO 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year 1:30 PM Virginia M. Worthington 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE EDENWALD DW50N If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
NOV. 8, 1911 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Virginia Months 1 □ M 2 👿 F 92 Yrs. 339-09-0622 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits Baltimore Towson 1 ☐ Yes 2 No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Rd. 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) +4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Katie Μ. Mahon Faris Lee Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Faris Worthington/ Son 3 Carousel Ct. Wilmington, DE. 19808 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 反 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 3-4-04 Towson, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or conshock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final meumoura disease or condition resulting in death) Due to (or as a consequence of) Sequentially list sonditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 22 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 0 No 1 ☐ Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 🗆 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

**Funeral** 

Director

is marked other than "natural", or Itams 23s or 28e-f show treumatic event, the Medical Examinar inside inclined

Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' ury or other treumatic event, the My

permit. Page Deportment of Important: If any injury or once.

iled within 72 hours after

Baltimore, Maryland 21215-0036

the burial-transit certificate has this of or Attending F After t Director: filled in by To the Hospitel or within 24 hours aft To the Funerel Die

Examiner Physician/Medical ۵ Be Completed 2

27. Manner of Death Certification: Natural 2 Accident 3 Suicide 4 - Homicide 29a Certifier Medical

(Check only one)

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

	( ` _	/ /	1m	<i>h</i>	has	cian	
30. Name	and addre	ss of	person who complet	ed cause of dea	th (Item 23	a) (Type, P	nint)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

MAR 05 2004

32. Registrar's Signature

Noverna

DHMH 17 Rev 1/2001

State

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes O. O.

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5	/Medic Examin		4a. Facility Name (If not institution, give	11.		n, or Location of Death	4c. County of E	
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.	last birthday) If Under 1 Ye	ar If Under 24 Hrs. 8, Date	of Birth 9.	Birthplace (State or Foreign
62.	Director		412-64-02697	M 2 F 63	Months Day	ys Hours Min. (Mon.	nth, Day, Year)	Tenn.
	ryland how		Usual Residence of Decedent  10a. State  10b. County	10c. Cit	ty, Town or Location			10d. Inside City Limits
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5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Exertical forms the rediffice at	d by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 🎾 Divorced	12. Was Decedent Evern U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	I.S. 13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Specify Yes uban, Mexican, Puerto Rican, et do <i>Specify</i> :	s or No- tc.) 14. Race - A Black, V Specify:	merican Indian, thite, etc
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land	2 9 2 0	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, A	Aiddle, Maiden Sumame)	
Mary	12 shou h and M 7 is mar traumati		19a. Informant's Name/Relationship (Ty			et and Number or Rural Route	Number, City or Town, Stat	e, Zip Code)
	es 1 and of Healt fitem 2 r other		AUFUS SANO 20a. Method of Disposition		Place of Disposition (Name of cemetery, crematory or other p	Date Date	20c. Location - City	or Town, State
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and the same of th	Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations hat caused the death the cause on each line.  Due to (or as a consequence)	MOITA	ying, such as cardiac or respira	tory arrest,	Approximate Interval Between Onset and Death
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence)	ivence of): 3RD VASCUL	AR ACCIE	SENT	LIYEARS
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.O. Box	requires that the death cert een signed by the attendin hould be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	I death 3 Ectopic pregnar	DICY CERTIFICATION	TION APPROVED BY MEDICAL 23d. Date of Month	
rds, P.	sign d be	þ	Part II. Other significant conditions con	tributing to death but not resu	ulting in the underlying cause of	given in Part I. 23e.	Did tobacco use contribute	to the cause of death?  Probably 4 \( \sum \text{Unknown} \)
Vital Records,	aw is b	Completed	CHRONIC OBS	TRUCTIVE	PULMONAI	1 - 1 - 1	Was an autopsy prior t	autopsy findings available o completion of cause of
talF	Th ate pag	a)	HISTORY OF  25. Was case referred to medical	ALCOHO	LISM	1 ☐ \	Yes 2 No 1 ☐ Y	? es 2□ No
	S 5	To B	1 41 65 2 410	T	Ervoutpatient 3 DOA	other: 4 Nursing Home 5	Residence 6 □Other (S	oecify)
ion	Attending I r death. ector: After by the funer	ation	27. Manper of Death  1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury M 1(	ury at 28d. Desc ork? □Yes 2 □No	cribe how injury occurred	
Division of	l or Atteno after deatl Director: i in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory, office	e 28f. Local	tion (Street and Number or or Town, State)	Rural Route Number,
_	Hospital 4 hours Funeral ely filled	edicai Ce	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examination	cicien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurred at the tion and/or investigation, in my	time, date and place, and due to opinion, death occurred at the	o the cause(s) and manner time, date and place, and d	as stated. ue to the cause(s)
	To the I within 2. To the I complet	Σ	29b. Signature and title of certifier	gh mo	29c. Lice	nse number VILL(60)	29d. Date signed (Mo	100 4 28 2004
	1		34 Marry and addless of person who go	holying compa olydalath firem	BALTIMO	RITCHIE H RE MARYI	HIGHWAY,	225
	Sta Registra	- 1	31. Date filed (Month, Day, Year)  MAR 0 5	32. Registrar's Signat	ture		()	
			HM H 1 V V					

		ŀ	1 _ For	State of Marylan		nt of Health and te of Death	Mental Hygier	- <b>/</b> 11115   115   12   15   15   15   15
	Physici	an	1. Decedent's Name (First, Middle, Las	inski	- Corumou	10 01 D 0 a 11	2. Date of Death	Day Yeer 3. Time of Death 5:38 AM
	/Medic Examin		4a. Fecility Name (If not institution, give Johns Hopkins Bayvi	street and number)		r, Town, or Location of Deat		4c. County of Death NA
	Funeral Director		5. Social Security Number 6. Social Security Number 1	ex 7. Age (In yrs.	(Ast birthday) If Und Months	er 1 Year   If Under 24 Hrs Days Hours Min.	(Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State  10b. County  CAN	10c. Cit	y, Town or Location	dale		10d. Inside City Limits  1 Yes 2 □ No
	as or 28a	Il Director	10e. Street and Number	Anso.	10f. Z	ip Code	-3	Citizen of What Country?
336	d within 72 hours after death with the Maryland Jiene. r than "natural", or Iteme 23a or 28a-f ehow The Medical Examiner much be multified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1		edent of Hispanic Origin? (Secrify Cuban, Mexican, Puer 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
21215-0036	within 72 ene. than "nai	Completed	15. Decedent's Ec (Specify only highest gra			rual Occupation work done during most of wo use retired)	rking 16b.	Red Cross
land 2	id be filed ental Hyg ked othe ic event,	To Be Co	17. Father's Name (First, Middle, Last) Theodoxe	Schle	tzer		me (First, Middle, Maid	
Maryland	nd 2 sho		19a. Informant's Name/Relationship		19b. Mailing Addre		ural Route Number, Cit Rusedalu	y or Town, State, Zip Code)
Baltimore,	Pages 1 and the total of Hermint: If Item		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Specify	Removal from State	Place of Disposition (Nemetery, crematory of	ame of rother place)	Date 20c.	Location - City or Town, State
Balti	permit. Pages Department of Important: If I any injury or once.		21. Signatura of Figure at Service Liver	Thank	22. Name		Mid Valley 1	Dr Dossup, PA18434
*	Physician /Medical Examiner		23a. Part / Ener the disease, or com show or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deat one cause on each line.  a	pheumo		c or respiratory arrest,	Approximate Interval Between Onset and Death  45 MINS
	te be executed ysician and le burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conseq  Due to (or as a conseq				
68760,	w > 0	ical		. d				
.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of o	it death 3 □Ectopic			23d. Date of delivery Month Day Year
<u>α</u>	uires that t signed by Id be deta	þ	Part II. Other significant conditions of		sulting in the underlying	g cause given in Part I.		ouse contribute to the cause of death?
Vital Records,	hysician: The law require his cerificate has been sit I director, page 2 should b	Completed					24a. Was an autopsy performed	
Vita	s certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 & npatient 2	ER/Outpatient 3□	Other	ath (Check only one) Home 5 Residence	6 □Other (Specify)
sion of	ending Phys sath. or: After this he funeral di	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in	
Division	ital or Attendi irs after death. ret Director: A led in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not b determined		ome, farm, street, fact fy)	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital within 24 hours a To the Funerel Completely filled	Medicai		ysician: To the best of my kno niner: On the basis of examina and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
)	To th withir To th comp	Me	29b. Signature and title of certifier	y MD		RCS - 000	M	Date signed (Month, Day, Year)  AVUN   2004
			30. Name and address of person who J. Southing John	completed cause of death (Iter S Hopkins Rayvie 2004 32. Projector's Sign	m 23a) (Type, Print) W Mcdichl	Center 4940 E	astern Aver	nue 1224
P	St. Regist	ate	31. Date filed (Month ARY 0) 5	2004 32. Plegistrar's Signa	aturely Annual	E)		

			1 - State Registrar Unpend Item#2	State of Marylar Ba.27.Per ME.082					ene g. No. 2004	06895		
	Physicia		1. Decedent's Name (First, Middle, Last)	<b>~</b>	ADCo.			2. Date of Death Month February	22, 2004	3. Time of Death		
	/Medic Examin		4a. Fecility Name (If not institution, give s Johns Hopkins Hosp	treet and number)		4b. City, Town, or Location of Death  Baltimore  4c. County, of Death  MA						
	Funeral Director		X13-74-5264 /	M 2□F 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year 9. Birth	nplace (State or Foreign unity)		
	Maryland f ahow ied at	tor	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	MORE				10d. Inside City Limits Yes 2 ☐ No		
	s or 28a-	Funeral Director	10e. Street and Number 388 S. BRE	ADUIAY	., 0, ,	10f. Zip Code	1231	10	g. Citizen of What Co	untry?		
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatte event, the Medical Exam for must be molified at	by		2. Was Decedent Ever in L Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ocify Yes or No- Rican, etc.)	14. Race - Amel Black, White Specify:			
21215-0036	d within 72 ho giene. or then "natur , the wedical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation o completed) College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done of DO NOT use retired	during most of worki d)		6b. Kind of Business/I	ndustry		
Maryland	should be filed withind Mental Hygiene. I marked other than Imatic avent, the Mental Care of the Mental Care	To Be (	17. Father's Name (First, Middle, Last)  ARROLL JUNI	OR ADO	ock		18. Mother's Name	(First, Middle, M.	aiden Sumame)			
-	1 and 2 sho Health and em 27 le mo	K E	19a. Informant's Name/Relationship (Ty) NESALIE BAKEI	٩	421	ng Address (Street:	APOUS	BAL	City or Town, State, Z TO - Co-3	21227		
Baltimore	Page nent c ant: M ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, cre	pasition (Name of platory or other place)	EM FEB2	4-04 =	BACTO	rown, State  MD ·		
Balt	permit. Pa Departmer Important. any Injury once.		21. Signature of Uneral Service License	Atack	-7.0	2. Name and Address	F.H. 3	829 H	DSON 27	724		
	Physician		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the dea e cause on each line.  Chronic Alcoho		ter the mode of dyin	g, such as cardiac o	r respiratory arres	sť,	Approximate Interval Between Onset and Death		
To de	/Medical Examiner		resulting in death)  Sequentially list conditions,	Due to (or as a conse	quence of):							
· (	te be executed ysician and ie burial-transit	Examiner	if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse								
68760,		ical										
O. Box	the the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of deliment	very Day Year		
<u>a</u>	w requires that the been signed by should be detac	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	inderlying cause give	en in Part I.		acco use contribute to	the cause of death?		
al Records,		Completed						24a. Was an autopsy performing Yes 2	ed? prior to c death? No 1/X Yes	opsy findings available ompletion of cause of		
f Vital	S S	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	ospital:	<b>X</b> ER/Outpatier	nt 3 DOA Othe	26. Place of Death er: 4 ☐ Nursing Hor		) ice 6 □Other (Spec	ify)		
ion of	ding h. After fune		27. Manner of Death  1 Tanatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	yat k? Yes 2 □ No	28d. Describe how	v injury occurred			
Division	at or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str ify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,		
	To the Hospitat or Attanwithin 24 hours after deatl To the Funeral Director:	Medical C		sician: To the best of my kn ner: On the basis of examin and manner stated.								
•	To the within 7 to the comple	×	29b. Signature and title of certifier	us		29c. Licenso	e number .M.E.		d. Date signed (Month oruary 23,			
			30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,		nn Street	, Baltim	ore, Maryl	and 21201		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 8 2004	32. Registrar's Sign	gree A	sould						

				1 - For State Registrar	-		nd / Depa		of He	ealth and	Mental Hy	_		06896
				Decedent's Name (First, Middle, La	ıst)				<u> </u>		2. Date of De	ath		3. Time of Death
	1	Physici /Medic		Robert W. Armst	rong						March	Day	2004	1922 M
		Examin		4a. Facility Name (If not institution, give			2.76		wn, or L	ocation of Dea	ath	4c. County Harf		
	بالمات ا			Upper Chesapeake		7. Age (In yrs.		If Under 1 \		If Under 24 Hr	s. 8. Date of Bir	+h		and (State or Foreign
	ı	Funeral Director			1 M 2 □ F	58	Yrs.	Months D		Hours Mir		1946	Mary	State or Foreign
	A			Usual Residence of Decedent										
		show	٦٢	10a. State 10b. County 10b. Harfo:	rd	10c. Ci	ty, Town or Lo Ab i	ingdon					10	d. Inside City Limits 1 ☐ Yes 2 🛂No
N		filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or items 23s or 28s-f show with the Medical Exam or must be motified at	Director	10e. Street and Number				10f. Zip Co	nde.			10g. Citizen of	What Countr	
5%		3a or	Ī	3102D Cardinal V	Wav			101. 2.15 00	210	09		-		States
19		death	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	I.S. 13.	Was Deceden	t of Hisp	panic Origin? (	Specify Yes or No into Rican, etc.)	)- 14. Rac	ce - America	
`	98	or the	y Fu	1 ☐ Never Married 2 ☑ Married	1 🔯 Yes	2 □ No 190 etes: to 1	64	illes, specily		Specify:	ito nican, etc.)	Specif	ck, White, et	ite
	21215-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E		ates: LO I	,	dent's Usual C		ion		16b. Kind of B		
	-51	in 72 n "nai	Completed	(Specify only highest gr	ade completed)	45-)	(Give	kind of work of DO NOT use i	done du retired)	ring most of w	orking	160. Kind of B	usin <b>ess</b> /indu	istry
	212	d with giene.	Com	Elementary/Secondary (0-12)	College (1	-40r 5+)	maint	tenance	2			hosp	ita1	
	pu	be filed tal Hygie d other event, the	Be	17. Father's Name (First, Middle, Last John H. Armstro					1		ame <i>(First, Middl</i> e, n White	, Maiden Sumar	ne)	
	yla		2				101 11 11							
4	Maryland	0 = 17 =		19a. Informant's Name/Relationship		r					Rural Route Numbe Bel Air,			iode)
10	ē,	s 1 and 3 f Health Item 27 other tra		20a. Method of Disposition							Date	20c. Location		m, State
3	Ę	8° = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Speci		State Ba	Place of Dispo cemetery, crer yview (	Cremato	ry	3/8/	/2004	Baltim	ore, 1	1d.
3/	Baltimore,	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Lice		1		Name and A	mak	Funers	al Home o	of Bel A	ir, I	
				23a. Pagh. Enter the disease, or conspect, or heart failure. List only	prications that ca	aused the deal	th. Do not ent	er the mode o	Ma of dying,	cPhail such as cardia	Road, Bo ac or respiratory a	rrest,	Md · 2	1014 Approximate Interval Between
		Physician		disease or condition	. T		in ton	al H	er n	iation			-	Onset and Death
		/Medical Examiner		resulting in death)	Due to (	or as a consec	juence of):	A	/	0 1	`			- 11
2	×		7.	Sequentially list conditions,	b. Due to (	resner	asca (a	r All	cial	ant			2	9 Hours
+	_	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	R	+ Co	4:1	41	1	lact	*		2	9 House
ER	, oʻ	e be executed sician and e burial-transit		resulting in death) Last	Due to (	or as a consec	quence of):	. 1	-	0 -1	1			11
2000	68760	e × 6	edical	•	d. R	sht	Ceno	iel E	nd	erter	chang		3	2 Heins
	Вох	Se dir	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		come of pregnanth 2 Feta	ıl death 3 [	Ectopic pregr Other (speci				1.	te of delivery	y Day Year
2	<b>VO</b>	t the de by the tached	hyslo	1 ☐ Yes 2 Dolo 9 ☐ Unknown	9□ Unkno			J Other (specia	· <b>y</b> /					
100	ds, P	es the gned be de	ρ	Part II. Other significant conditions	contributing to de	ath but not res		nderlying caus		in Part I.	23e. Did to			cause of death?
57	COL	aw requir as been si 2 should	Completed	Hypert	en Sten 1	Hy pre-	lipid	enig.	7	aba co	24a. Was		Were autops	sy findings available pletion of cause of
51	72		Com	Aluge	Isch	mic	Hear	T	212	esse		rmed?	death?	
3	7≅	sician: Th s certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital						ath (Check only c			
10	10	Physic ralor	: To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 XIII	npatient 2	ER/Outpatien 28b. Time of		Other: Injury a	4   Isursing	Home 5 Resid	dence 6 Oth		
	on	th. : After s funer	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monti	h, Day Year)	Injury	M	Work?	s 2 □No	200. 20001120 1	iow injury occur		
2	Division	I or Attendi after death. Director: A I in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	280. Place	of Injury - At h	ome, farm, str	eet, factory, of	ffice		28f. Location (S City or Tov	Street and Numb	er or Rural I	Route Number,
150	ā	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certificately filled in by the funeral inrector.	Cer							and the Carter	the Albertan		c=-95	
#370506		To the Hospita within 24 hours To the Funeral completely filled	edical	29a. Certifier (Check only one) 1 Certifying Pl	hysician: To the miner: On the ba and mann	isis of examina	owledge, death ation and/or in	occurred at t vestigation, in	he time, my opir	, date and place nion, death occ	e, and due to the curred at the time,	cause(s) and ma date and place,	anner as stat and due to tl	ed. he cause(s)
#	)	To the Hos within 24 ho To the Fun completely f	Me	29b. Signature and title of cerafier				29c. Li	icense r	number		29d. Date signe	d (Month, Da	Ry, Year)
		4		1 Logles	Kel	4	MD	P	3	065=	3	Tasela	3,	2004
		10		30. Name and address of person who	completed cause	of death (Iter	n 23a) (Type,	Print)	Doa	be 12	ive, Be	ATA	210	14
	7.6	Sta	te	31. Date filed (Month, Day, Year)		egistra 's Signa	7-10	-ver 4	1	V		. , ,		
r)		Registr	ar	MAR O	8 2004	Bustin	· do	Ana D	9					

DHMH 17 Rev 1/2001

			1- For Amend Ite	m #10	State o	f Marylan er fh (	d / Depa 3829 3	rtment 16/04 tificate	of H	ealth a Death	and N	lental Hy	giene Reg. Na	200	4 06897
			1. Decedent's Name (First, Mic									2. Date of De	ath		3. Time of Death
	Physic /Medi		Catherine Ail	een A	mes							Month March	Da 3	y Yeer 2004	
7	Examir		4a. Fecility Name (If not institut	ion, give st	reet and nu	nber)		4b. City, T	own, or	Location of	of Death		40	. County of De	
			St. Joseph Nu		Home					isvil		T		Baltin	
· Fr	Funeral Director		5. Social Security Number 215-07-4956	6. Sex	M 2 <b>⊠</b> F	7. Age (In yrs. 92	Yrs.	If Under 1 Months	Days	If Under: Hours	Min.	8. Date of Bin (Month, De 02/01/1	y, Yeer,		rthplace (State or Foreign country)
	and		Usual Residence of Decedent  10a. Slate 10b. Cour	ty		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	the Marylan 28a-f show	ō	MD Ba1		_		0 - 1 -								1 ☐ Yes 2 ☑ No
	28a	Director	102 Steet and Number D	timor	е		Cator	1SVIII					10g. Ci	izen of What C	Country?
	h with		222 Tugwell D						2122	) Q				USA	•
	ter deat Itams	Funeral	11. Marital Status		2. Was Dece	edent Ever in U.	S. 13.				gin? (Sp	ecify Yes or No Rican, etc.)	-	14. Race - Am	erican Indian,
36	s t and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "netural", or items 23e or 28a-f show other traumatic event, the Medical Examinational be notified at	by Fu	1 X Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorc		1 ☐ Yes If Yes, Gir Year or D	2 <b>№</b> No	i	1 ☐ Yes 2	_	Specify:	, - 46110	rican, etc./		Black, Wh	
Š	2 hou	ted	15. Deced	ent's Educa	ation		16a. Deced	leni's Usual	Occupa	tion	- 0		18b. K	ind of Busines:	White s/Industry
21215-0036	hin 7.	Completed	(Specify only high Elementary/Secondary (0-12		completed) College (1	-4or 5+)	(Give life. l	kind of work DO NOT use	done do retired)	uring most	of work	ing			<b>,</b>
21	ad wit	COU	12		O o mogo (	40.01,	Se	creta	ry				Le	gal Pro	fession
Maryland	d 2 should be filed within 7 lith and Mental Hygiene. 27 Is marked other than "r traumatic event, the Mad	Be (	17. Father's Name (First, Middle Alvin Garriso)	e, Last) n. Ame:	S					18. Mothe	r's Name	e (First, Middle,	Maider	Sumame)	
yla	Meni	2	- George Ames -									e_Doyle			
Mar	12 sh h and 7 is rr		19a. Informant's Name/Relatio									al Route Numbe			
	t and Healt em 2 ther		Joan Costello 20a. Method of Disposition	/Frie:	nd/POA		1004 lace of Dispo	Magru		Ave.		ltimore	_		
Baltimore,	8 = 5		1 Burial 2 ☐ Crematio		moval from	State	emetery, cren	natory or oth	er place	· I				ocation - City o	
Ħ	artmen cortant: injury		'4 ☐ Donation 5 ☐ Other  21. Sign Ture of Funeral Service			New	7 Cathe			of Facility	3/06	/2004	Bal	timore,	MD
Ba	Depar Impor		To war	-			St	erlin 6 Edm	g As onds	hton on A	′Sch ve.	wab Fun Baltim	era ore	Home, MD 21	Inc. 228
			23a. Pert . Enter the disease, shock, or heart failure. L	or complications	ations that co	aused the death ach line.	n. Do not ente	er the mode	of dying	, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	а		JREN	NA								Onset and Death
	/Medical Examiner		resulting in death)		Due to	or as a consequ	-								
	TAGINITE:	_	Sequentially list conditions,	b.	Due to	or as a consequ		Alu	sne	-					5 months
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate Enter underlying Cause (Disease or injury	₹	D09 10 1	or as a consequ	refice of):								
2	al-tra	xar	that initiated events resulting in death) Last	C.	Due to (	or as a consequ	uence of):								
8760,	cate be executed obysician and the burial-transit	dical		d.											
9	tifical ng phy as th	Med	15 55141.6												
Š	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23		come of pregnatirth 2 Tetal		Ectopic pred	inancy					23d. Date of de	
.O. B	it the dea by the at tached fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4☐Pregn 9☐Unkno	anl at lime of de		Other (spec						Month	Day Year
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Division		Certification:	3 Suicide 6 Coul 4 Homicide dete	mined	28e. Place buildin	of Injury - AI hong, etc. (Specify	me, farm, stre	et, factory, o	office		1	28f. Location (S City or Tow	treet an n, State	d Number or R )	ural Route Number,
	Hospital		29a. Certifier 1 Certify	in a Dhuais	inn T- the	5									
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical	(Check only 2 Medical one)	I Examine	r: On the ba	best of my know sis of examinati er stated.	ion and/or inv	estigation, in	my opi	, date and nion, death	place, a	and due to the c ad at the time, d	ause(s) late and	and manner as place, and due	s stated. e to the cause(s)
	To the within 2 To the I complet	Me	29b. Signature and title of certif	er				29c. t	icense i	nedmun		2	9d. Dat	e signed (Mont	h, Day, Year)
)			· XW	L.	- M	( ).		1	)4	00	12	. 1	THE	ARCH !	1.2004
	K		30. Name and address of perso	n who com	pleted caus	of death (Item			,	0	-			4 -71	'
				007	2001	nu '		+ PRDC	44	(10/	FD/	SUITED	PYOY	CATON	actic on aning
	Sta Registr		31. Date filed (Month, Day, Yea		32. R	egistrar's Signat	ure		*				,		
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 6.00 AM **Physician** Catherine Fern Aldridge March 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 7839 Wynbrook Road Colgate Baltimore | COlgale | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 22, 19 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) **Funeral** 1 M 20XF 1926 Maryland 214-22-6656 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral', or items 23a or 28a-f ahow Exertine mant be nettined at MD 1 Yes 2000 Baltimore Colgate Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7839 Wynbrook Road U.S.A. 21224 r death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic avant, the Medical Exarisinat once. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Department Store 12th Salesperson 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Myers Marie Weetenkamp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Jean Dickens/Daughter 4806 Hilltop Court Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore National 3/5/04 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles S. Zeiler& Son, Inc. 21. Signature of Euneral Service Lightsee 6224 Eastern Avenue Baltimore, Maryland 21224 Denuce 1100521 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Hear **Physician** 20146 /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and the for use as the burial-tran Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 🗆 No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed page 2□ No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred . Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3015T. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 08 Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of IVI	aiyiai		-		Death	r ivieritai m		2001	05000
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	ylend		10a. State 10b. County		10c. Ci	ty, Town	or Location				-	1	IOd. Inside City Limits
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	with th	Funeral Director	10e. Street and Number	Augnus			10f.	Zip Code	215			on of What Cour	ntry?
	ne 23	erai	3300 Leighton  11. Marital Status	12. Was Decedent	Ever in U	l.S.	13. Was De			Specify Yes or N		I. Race - Americ	an Indian
21215-0020	72 hours efter death with the Marylend "naturel", or items 23a or 28a-f show balcal Examiner must be notified at		1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	Armed Forces?  1 Yes 2X  If Yes, Give Year or Dates:					an, Mexican, Pue Specify:	(Specify Yes or N erto Rican, etc.)		Black, White,	etc.
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ylar	should be find Mental I	To Be	Edon J. Burrus	5					Madie	Saunde	rs		
Maryland	l 2 sho bend l s ma raum		19a. Informant's Name/Relationship (							Rural Route Numb	-		
	1 end Health em 27		E. Florence Do	gan - Si	20b. F	Place of D	isposition (	lame of		. Balto		ID 2121 ation - City or To	
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Baltimore,	permit. Pages 1 end 2 should be filed within Department of Health end Mental Hygiene. Important: if Item 27 Is marked other than any injury or other traumatic event, the Middle.		21. Signature of Funeral Service Licer				22. Name	and Addre		itter F	unera	al Home	
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The Mary	Physician /Medical Examiner	ıer	Immediate Cause (Final disaase or condition resulting in death)		ws	ele		Car		scular		ease	Onset and Death
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Ĭ.	Physician: Th this certificate ral director, pe	Be	25. Was case referred to medical examiner?	Hospital:				Oth	or	eath (Check only			
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			For State Registrer	State of Maryland / De	epartment of Hea			ene 2001	+ 06901
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			5. Social Security Number 6. Sex	7. Age (In yrs. last birthd		Under 24 Hrs.   8	Date of Birth	9 Birt	holana (State or Foreign
	Funeral Director			A 2□F Yrs	Months Days H	Hours Min.	B. Date of Birth (Month, Day,	(ear) (9/7) Co	holace (State or Foreign
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	irylan show		10a. State 10b. County	10c. City, Town o	Location				10d. Inside City Limits Yes 2 □ No
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	with ti		10e. Street and Number	1 - Da APT	B 10f. Zip Code	2./	10	g. Citizen of What Co	A.
	death with the Maryland ms 23s or 28s-f show crives be notified at	Funeral	11. Marital Status	. Was Decedent Ever in U.S.	13. Was Decedent of Hispa	anic Origin? (Speci	fy Yes or No-	14. Race - Ame	rican Indian,
۵			1 Never Married 2 Married	Armed Forces? 1  Yes 2  No	If Yes, specify Cuban, A	Mexican, Puerto Ri	can, etc.)	Black, White	e, etc.
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and	d 2 should th and Mer 7 Is marks traumatic	-	19a. Informant's Name/Relationship (Type	, <i>Print)</i> 19b. M	lailing Address (Street and	Number or Rural I	Route Number,	City or Town, State, Z	Tip Code) 2/030
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Baitimore,	Pages 1 an nent of Heal int: If Item 3 iry or other		20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □ Rei	cemetery	sposition (Neme of crematory or other place)	FER	17 2	0c. Location - City or	LLS.
≣			`4 □Donation 5 □ Other (Specify)	HOLY	KEDEEMER		004 6	DALTO - 1	Ø·
Ba	permit. Departi Import any inj		21. Signature of Funeral Service Licensee	Beef O.	22. Name and Address o	11 282	9 HUD	5013 51	r
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	/Medical		disease or condition resulting in death)	CEREBRO VA	+SCULAR	ALCID	ENT		
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	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	SEPSIS  Due to (or as a consequence of):					
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	ital o	Cer							
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely illied in by the funeral director,	edical	29a. Certifier 1 ← Certifying Physic (Check only one) 2 ← Medical Examine	cian: To the best of my knowledge, dur: On the basis of examination and/or and manner stated.	leath occurred at the time, or or investigation, in my opinio	date and place, an on, death occurred	d due to the cau I at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
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	F ≤ F ŏ		•	- This	RES	000	F	EB, 13;	2004
	1)		30. Name and address of person who com	pleted cause of death (Item 23a) (Ty	pe, Print) MICHE	DDO L KAFRI	DUNI MA	3	
			GOODS AMARITAN I		OCH RAVEN E	BLUD BA	LTIMORE	MD 21239	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature					
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DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State	of Marylar				ealth a	and M	F	Reg. No.	Z 11 11 16	06902	)
	Physicia /Medic		1. Decedent's Name (First, Middle, L	ast)	BR	?own	,				2. Date of Dea Month	Day	awy	3. Time of Death	
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		·	Genesis Loch R					wson		04 (1			Baltimo		_
	Funeral Director		216-62-7730	Sex 1 □ M 2 🔀 F	7. Age (In yrs. 47	last birthday) Yrs.	Months	r 1 Year Days	If Under a	Min.	8. Date of Birtl (Month, Day 3-10-5	y, Year)	9. Birth Con Md.	nplace (State or Foreign untry)	
	yland how		Usual Residence of Decedent  10a. State 10b. County  Md. NA		10c. Ci	ty, Town or Lo Baltim					<del> </del>			10d. Inside City Limits	_
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1	3e or 2	al Dire	10e. Street and Number 1017 Bonaparte A	ve.				Code 21218				-	zen of What Cou JSA	untry?	
	oud be filed within 72 hours after beam with the maryland Mental Hygiene. A street other than "natural", or items 23e or 28e-1 show attic event, the Marylan Examiner mainteen cilified at	Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married	Armed F	2 X No	ĺ				gin? (Spe , Puerto i	cify Yes or No- Rican, etc.)	. 1	14. Race - Amer Black, White		
	tural', o	by	3 Widowed 4 Divorced	If Yes, G Year or I	ive Dates:	16a. Dece	1 ☐ Yes		Specify:				Specify: B]	ack	
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1	tygiel ther ti		10th grade 17. Father's Name (First, Middle, La:	xt)		Hou	seke	eping		r's Name	(First, Middle,		Lton Hot	:eı	_
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5	Du E E		19a. Informant's Name/Relationship				•						Town, State, Z		
, כו	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tre		Mary L. Brown 20a. Method of Disposition	Mothe	20b. F	Place of Dispo cemetery, crer	sition (Na	me of			altimor		Ad. 212 cation - City or 1		_
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	permit. Departrr Importa eny inju		21. Signature of Funeral Service Lie	50S00	1 2 10			nd Addres	s of Facilit				Md. 21		
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O. DOX 0	that the death certifics ed by the attending ph detached for use as ti	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 Live	utcome of pregnibirth 2 Feta prant at time of conown	aldeath 3□	Ectopic p	3				2	23d. Date of deli-	very Day Year	
olds, r	w requires that the been signed by the should be detach	by	Part II. Other significant conditions  And, LITUM HEN	contributing to	death but not res	sulting in the u	nderlying SAU!	cause give	on in Part I.				se contribute to ∃No 3⊟Pro	the cause of death?	
ingau i	The taw requiry ate has been si page 2 should to	Completed									24a. Was autop perfor 1 ☐ Yes	sy rmed?	24b. Were aut prior to death? 1  Yes	topsy findings available ompletion of cause of	
VILA	ysician: s certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2√ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 D	OA Othe			(Check only on the 5 ☐ Resid		3 □Other (Spec	ify)	
	Jing Ph	tion: T	27. Manner of Death  1 ☑ Natural 5 ☐ Pending		of Injury nth, Day Yeer)	28b. Time of Injury	М	28c. Injury Work		2	28d. Describe h			QUAR.	_
DIVISION :	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2.	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place	e of Injury - At h ding, etc. (Speci	ome, farm, str fy)					28f. Location (S City or Tow	Street and m, State)	d Number or Ru	ral Route Number,	
:	24 hour 25 hour Funera stely fille	edical (	29a. Certifier 1 Certifying (Check only 2 Medical Ex	eminer: On the											
	To the within To the	Me	29b. Signature and title of certifier			···-	29	c. License	number			29d. Date	e signed (Month	, Day, Year)	_
	N		Manha La	ynuna	o MI	7	Drict\	05	45/8		9/	2/0	4		_
	1		30. Name and address of person why NIARTHA ILAUMUND	0 5601	wanka	un Be		falty	no Ni	1021	237				
	Sta Registi		31. Date filed (Month, Day, Year)	8 2004	Registrar's Sign	ature	Low	40							

			1 - For Registrar	State of Maryla	and / Depa <i>Cei</i>	artment o	of He	alth ar eath	nd M	lental Hyg	giene (	004	069	03
			1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	th	Voor	3. Time of	f Death
	Physici /Medio		Raymond W. Bos	chert						March	1 1	2004	2:00	РМ
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Tov	n, or L	ocation of I	Death		4c. Cour	nty of Death		
			997 Jason Ct.			Gambr						Arund	le1	
	Funeral		5. Social Security Number 6. Sex	M 2 T E	rs. last birthday)	If Under 1 Y Months D		If Under 24 Hours	Hrs. Min.	8. Date of Birth (Month, Day	Year)	Count		or Foreign
	Director		217-34-9300	6	5 Yrs.					8/6/19	38	Mary	land	
	and w		Usual Residence of Decedent  10a. State  10b. County	10c.	City, Town or Lo	cation						10	d. Inside C	ity Limits
	Mary	ō	Maryland Anne Aru	ndel G	ambri11:	5							1 🗀 Yes	2XXN0
	28a	Director	10e. Street and Number			10f. Zip Co	de			1	l0g. Citizen o	of What Count	try?	
	38 o	0	997 Jason Ct.			21	054				U.	S.A.		
	72 hours after death with the Maryland Insturel', or Items 23e or 28e-f show dical Examinet must be notified at	Funerai	11. Marital Status	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Vas Decedent	of Hisp	anic Origin	n? (Spe	ecify Yes or No- Rican, etc.)		ace - America		
9	after or Ite	T I	1 ☐ Never Married 2 🂢 Married	XXYes 2 ☐ No If Yes, Give				Specify:	Puento	nican, etc.)		lack, White, e		
ဋ	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		¹□Yes XX					Spec	Whi	te	
<u>7</u>	natu	Completed	15. Decedent's Educa (Specify only highest grade		16a. Deced	tent's Usual O kind of work d DO NOT use re	ccupatione dur	on ring most o	f worki	ing	16b. Kind of	Business/Ind	ustry	
7	Mithin the shape of the shape o	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		chnicia					Auto	motive		
2	Hygie Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)		100	JIIIIICIA		8. Mother's	Name	e (First, Middle, i				
an	d be and a lead o	00	Andrew John Bosche	rt			1			Koskows				
Maryland 21215-0036	Shoul nd Me mark mark	ဥ	19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailir	g Address (St	reet and	d Number o	o <i>r Rura</i>	al Route Number	, City or Tow	m, State, Zip	Code)	
Š	nd 2 lith al 27 Is r trau		Wanda L. Boschert	(wife)	997 .	Jason C	Ct.	Gambr	<b>i</b> 11	s, MD 2	1054			
ē,	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition	206	. Place of Dispo cemetery, cren	sition (Name o	of r nlace)	I		ate	20c. Location	n - City or Tov	vn, State	
Ê	Pages nent of I ant: If its ury or o		XX Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	noval itom State	len Have				6/2	004	Glen B	urnie,	MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23e or 28a-1 show entry injury or other traumatic event, if a Madical Examinat must be notified at once.		21. Signature of Funeral Service Liberge		22	. Name and A	ddress	of Facility	II -	D A				
m	89528	12.43	13- y. m	-		2 Ridge	1y .	nerai Ave.	Ann	me P.A. apolis,	MD 21	401		
8760,	death certificate be executed  Ray  Ray  Ray  Ray  Ray  Ray  Ray  Ra	dical Examiner	shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.  d.	Due to (or as a cons  Due to (or as a cons	equence of):	ztz's		Bus:	ţ,	t Con	ncer		Interval Bet Onset and I	
.O. Box 68	ne death certii the attending thed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of prec 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregn					l l	Date of deliver Month	•	Y <del>o</del> ar
rds, P	The law requires that the has been signed by sage 2 should be detact	þ	Part II. Other significant conditions conti	ibuting to death but not r	esulting in the u	nderlying cause	e given i	in Part I.		23e. Did tob		ntribute to the	ecause of d	
Vital Record		Completed							_	24a. Was a autops perform	n 24b	prior to com death?	sy findings a	available ause of
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?						Death	(Check only on	e)			
of	S S 5	ဥ	1 185 2 NO		☐ ER/Outpatien			4 🗀 IAUI 211	-	ne 5 Reside				
E C	ling f	ion	27. Mann Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Mork?	t s 2⊡No		28d. Describe ho	w injury occi	nried		
Sic	Attending ir death. ector; After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home farm str			5 2 110	-	28f. Location (St	reet and Nur	nher or Rural	Route Num	her
-	after Direct	ertification;	4 ☐ Homicide determined	building, etc. (Spe	cify)	ou, ractory, on	1100			City or Town				507,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier Certifying Physic (Check only one)	cian: To the best of my kir: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at threstigation, in r	ne time, my opini	date and p	olace, a	and due to the ca	ause(s) and nate and place	nanner as sta , and due to t	ted. the cause(s	)
	To the within To the compl	Me	29b. Signature and this of certifier	1/10	1	29c. Lid	cense n	umber	ت _	29	9d. Date sign	ned (Month, D	ay, Year)	26
	10		30. Name and address of person who com	pleted cause of death (It	em 23a) (Tvího	Print)	,	-/	) )		larc	4 4	100	7
	Sta	10	31. Date filed (Month, Day, Year)	32. Registrate Sig	J H0	50-10	4/6	DIM	7)	O/th	Brin	n (4).	106	1
	Registr		MAR 0 8	. 81	w be	Soul	6	1						

			For 1 = State Registrar	State	of Ma	aryland	-	artmen rtificate			Mental H	/giene Reg. No. 2 (	004	06904
	Physici	an	1. Decedent's Name (First, Midd								2. Date of D Month	eath Day	Year	3. Time of Death
	/Medic	al	Geraldine  4a. Facility Name (If not institution			bel	L	4b. City,	Town, or	Location of Dea	March		y of Death	3:10 P M
	Examin	er	Gilchrist Ho			r		Tow				Balt	*	
	Funeral Director		5. Social Security Number 228-28-8384	6. Sex		79	as <i>t birthd</i> ay) Yrs.	If Under Months	1 Year Days	if Under 24 Hr Hours Mir	8. Date of B (Month, 19	ray, Year 924	9. Birth	place (State or Foreign ntry)
	land ow		Usual Residence of Decedent  10a. State 10b. Count	у		10c. City	, Town or Lo	ocation						10d. Inside City Limits
	death with the Maryland ms 23a or 28e-f ehow	ctor	MD How	ard		E	llico	tt C	ity					1 ☐ Yes 2 🙀 No
	with th	Funeral Director	10e. Street and Number					10f. Zip				10g. Citizen of		ntry?
	eath v	eral	9209 Maple R		ve Decedent E	Ever in U.S	S. 13.	Was Deced		1042 spanic Origin? (	Specify Yes or N	U. S		can Indian,
36	≽ <u>₽</u> ₽	by Fun	1 Never Married 2 Ma 3 Widowed 4 Divorce	rried 1 7	lForces? es 2√⊡N			lfYes, spec 1 ☐ Yes			Specify Yes or N rto Rican, etc.)	Bla	rck, White,	etc.
5 00 S	72 hou	eted	15. Decede (Specify only high	nt's Education	ed)		16a. Dece	dent's Usua kind of wor	al Occupa	ation furing most of we	orking	16b. Kind of I	Business/Ir	ndustry School
19/04 31 gan. Maryland 21215-0036	d within piene. r than	Be Completed	Elementary/Secondary (0-12) 12th		e (1-4or 5	+)	Teacl					System		JCHOOT
7	1 and 2 should be filed within thealth and Mental Hygiene. om 27 is marked other than their treumatic event, the Mental Hygiene.	BeC	17. Father's Name (First, Middle						data dinana		ame (First, Middi		me)	
	hould id Men marke matic	2	William Tay				19b. Mailir	na Address	(Street a		e Pegr		. State. Zii	o Code)
	alth an 27 is		Cynthia Heb		augh	ter								
aldina 8/2/04  Baltimore, Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than eny injury or other treumatic event, I.I.a. M. ODGe.		20a. Method of Disposition 1 Burial 2XX remation		om State	CE	ace of Dispo	matory or o	ther plac		Date	20c. Location		
Z i	nit. Pa artmen ortent: injury		*4 □Donation 5 □ Other ( 21. Signature of Funeral Service		- 0 0	Met	ro C				/04 tter F	Balto uneral		es,Inc.
7	permi Depa Impo eny ir		Merbert	E. N	ull	er					ls Pkw			
3			23a. Part1. Enter the disease, of shock, or heart failure. Lis	t only one cause o	on each lin	10.	. Do not ent	er the mod	e of dyini	g, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
7	Physician /Medical	Н	Immediate Cause (Final disease or condition resulting in death)	a	UNG to (or as a		Ancel	2					^	nonthe
1,6	Examiner		Sequentially list conditions	b	to (or as a	a consequ	ierice or).							
D	ed sit	niner	Sequentially list conditions, it any, leading to immodiate cause. Enter Underlying Cause (Disease or injury	209	to (or as:	а сопвеци	ianne of):							
26	execut in and ial-trar	Examiner	that initiated events resulting in death) Last	c	to (or as a	a consequ	ence of):						1	
pte (1)	certificate be executed nding physician and use as the burial-transit	cal		d										
2 ×	certific ding p	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome	of pregnar	ncy					23d D	ate of deliv	Anv
000	es that the death cer igned by the attendir be detached for use	Physician/Med	in the past 12 months?  1  Yes 2 No 9 Unknown	4 <u>□</u> Pr	ve birth regnant at nknown			Ectopic pro					onth	Day Year
) ds. P	Attending Physicien: The law requires that the death regest.  After this certificate has been signed by the atter effor. After this certificate has been signed by the funeral director, page 2 should be detached for up	ρ	Part II. Other significant condit	ions contributing t	o death bu	ut not resu	ilting in the u	nderlying ca	ause give	en in Part I.		tobacco use cor Yes 2 ☐ No		he cause of death?
Division of Vital Becords.	he law requir e has been s ige 2 should	Completed							<u>-</u>		per	opsy ormed?	prior to co death?	opsy findings available impletion of cause of
Te de	ysicien: The is certificate hadirector, page	Be Cc	25. Was case referred to medic	al						26. Place of De	1  Yes eath (Check only	one)	1 🗆 Yes	2 No
> >	Physic this ce	ဥ	examiner? 1 Yes 2 No		□Inpatie		ER/Outpatier		-	AVENUTSING	Home 5□Res			(y)
ou o	ding P h. After i funera	tlon:	27. Manner of Death Natural 5 Pend 2 Accident inves	ing (A igation	ate of Injur Month, Day	Year)	28b. Time of Injury	1 2 M	8c. Injury Work	at ? /es 2 □ No	28d. Describe	how injury occu	rred	
Divisi	To the Hospitel or Attendia within 24 hours atter death. To the Funerel Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Pl	ace of Inju	iry - At ho	me, farm, str )	eet, factory				(Street and Num own, State)	ber or Run	al Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	Medical Ce	(Check only 2 Medica	ng Physician: To I Examiner: On th	e basis of	examinat	wledge, death	n occurred a	at the tim	e, date and place	e, and due to the curred at the time	cause(s) and m	anner as s	stated. the cause(s)
	o the rithin 2 o the omple(	Med	one) 29b. Signature and title of certifi		nanner sta	ted.		29c	License	number		29d. Date signe	ed (Month,	Day, Year)
	FSFO		Afther	In.	2				) 5	8303	•	March	2,7	2004
			30. Name and address of person	tes who	6 4	eath (Item	23а) (Туре,	Print) le.	12 2	- Balti	more n	10 2120	9	
	Sta Registr		31. Date filed (Month, Day, Yea MAR 0 8 2004		2. Registra	ar's Signar	ure A	arks	/					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner BALTO If Under 1 Year 7. Age (In yrs. Jest birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 218-28-Months Days 1 □ M 2 X F Director Pages 1 and 2 should be filed within 72 hours after daath with the Maryland 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2□No BALTIMORE Be Completed by Funeral Director ATDNSVILLE 10e Street and Number 10g. Citizen of Whet Country? U.S.A MONDSON 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritel Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 M No If Yes, Give Baltimore, Maryland 21215-0020 Specify 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry OWN HOME Department of Health and Mental Hygiene, important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) OME MAKER N 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWIA 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a Informant's Name/Relationship (Type, Right) LANDA TOWNSON MU 600 oden. Of 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematery or other) 20c. Location · City or Town, State Burial 2 Cremetion 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Add 23e. Part 1. Enter the disease of complications that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician · MULTIPLE MYCLOMA Immediate Ceuse (Final disease or condition resulting in death) /Medical 115 12745 Examiner Due to (or es a consequence of) Be Completed by Physician/Medical Examiner l or Attending Physician: The law requiras that the death certificate be executed after death. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) To the Hospital or Attending Physician: The law requiras that the de-within 24 hours after death.

When the Funeral Director: After this certificate has been signed by the e-completely filled in by tha funaral director, paga 2 should be detached it Part ff. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 DUnknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 🗆 Yes 2 1 No 1 ☐ Yes 2 ☐ 100 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Menger of Death 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) Medical 29b. Signature apolitile of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) D40491 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Yed MA WAZ 800 NWK Ham Ferny Ed Linkticon 21090 31. Date filed (Month, Dey, Year) 32. Registray's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			Decedent's Na	me (First, Middle, La		i iviai yia	•			Death	2. Date of D	Reg. No. 2	004	06906
	Physicia										Month	Dey	Year	11:07 AM
1	/Medic			onia F. C						lb. City, Town, o	r Location of Dea	th 4c. Cour	2004 ity of Deeth	- 11.0/ AM
	Examin	er	SAINT	4	_ //	LTHC	MOF			BALTIMO			.,	
	Funeral		5. Social Security	Number 6.	Sex		s. lest birthday)		r 1 Year	If Under 24 Hr		rth	9. Birth	place (Stete or Foreign ntry)
	Director		220-07- Usuel Residence	9100	1□ M 2∏F	8	4 Yrs.	Months	Deys	Hours Min	8. Date of Bi (Month, D Dec • 10	1919		rland
	ytand		10a. Stete	10b. County		10c. C	City, Town or Loc	ation						10d. Inside City Limits
	Mar	ţ	MD	Baltim	ore	Ca	atonsvil	le						1 ☐ Yes 2√ No
	# 128	ě	10e. Street end N	umber				10f. Zij	p Code			10g. Citizen o	f What Cou	ntry?
	15 will	a	707 Mai	den Choic	e Lane,	Bldg.	9, T-19	2	1228			USA		
21215-0020	urs a	by Funeral Director		rried 2 Married 4 Divorced	12. Was Dece Armed For 1  Yes If Yes, Giv Yeer or De	rces? 2 DXNo e		/as Dece Yes, spe ☐ Yes		ispanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	1	ace - Americ lack, White, hity: whi	etc.
5-0	72 hc	Completed	/Sne	15. Decedent's E	ducation		16a. Deced	ent's Usu	al Occup	ation during most of w	orkina	16b. Kind of	Business/In	dustry
21	ighin	ם	Elementary/Sec		College (1	-4or 5+)	life. D	ONOT	ise retired	) most of the	orking			
	filed with Hygien ther the	် ဂ	12		22		Secre	tary				Banki		
밀	d oth	To Be		First, Middle, Last						18. Mother's Na	ame (First, Middle	, Maiden Suma	ame)	
Ş	should be ind Mental is marked of	၉	Arthur	L. Fowler						Gertrude	e Gorsuc	n		
Maryland	C/ C/ = 0	1	19a. Informant's h	Name/Relationship (	Type, Print)		19b. Mailing	Address	s (Street	and Number or F	Rural Route Numb	er, City or Tow	n, State, Zip	Code)
	1 and Health em 27		17 17	L. Chenow	ith - so						ithersbu	-	20882	
Baltimore,	of H		20a. Method of Dis	sposition ! DCremation 3 [	Removal from S	State 20b.	Place of Dispos cemetery, crem	ition (Nai atory or o	me of other plac	e)	Date	20c. Location	- City or To	own, State
Ë	Pag ment ant: I	ł	4 Donation	5 ☐ Other (Specia	<b>5</b> y)	Bal	ltimore	Wash	. Cr	ematory	3/05/04	Laurel	, Mary	yland
a	pemit. Pages 'Department of H Important: If ite eny injury or of pnce.		21. Signature of	di Cal Corvice Li	see -		22. Gar	Name ar	nd Addres	s of Facility	neral Ho	ne at Me	adowr:	idge MP.,Inc
0	80 E 5 8	- 1		T/C	1 -	Mois	290 725	0 Wa	shin	aton Bly	vd., Elk	ridae.	Md 2	1075
		$\dashv$	23a. Part1. Enter	the diseese, or com act failure. List only	plications that ca	•								Approximete
1	Physician		SHOCK, OF HE	agt failure. List only	one cause on ea	ach line.							[	Interval Between Onset end Death
1	/Medical		Immediate Ceuse disease or conditi	(Final	80	icen 7	ing an	0112	18m	of a	arto		1	house
	Examiner		resulting in death)		e. 12		s a consequ		10/11	- a	epin		1	Trons
	n =	Ē			10	14	hom	11	ora	× 100			1	harris
	oute nd ransi	E E	Sequentially list of	onditions.	b	Due to (	or es a consequ	_	-				- 1	10001
ó	an an	Ĭ.	Sequentially list of if eny, leading to it cause. Enter Und Ceuse (Disease o	mmediate erlying	AL	honor	colo no	21.0		200	4		i	vears
68760,	cate be executed physician and s the burial-transit	Medical Examiner	that initiated event resulting in death)	S	c	Due to (	or es a consequ	ence of):	6	T ac	ria			1000
	ng pt	<u>8</u>	resulting in death)	Last									İ	
Вох	aath cer attandir I for usa	2			d									
	daat ne att ed fo	200	Part II. Other signi	ificant conditions c	ontributing to dea	ath but not re	sulting in the und	derlying o	ause give	en in Part I.	23b. Did	tobacco use c	ontribute to	the cause of death?
P.0	ras that tha da signed by the a be detached i	Physician/					_				10	Yes 2 No	3 ☐ Prot	bably 4 Unknown
	gned be de	2												
Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed										an autopsy imed?	ava	ere autopsy findings ailable prior to mpletion of cause
ě	e law has l	립											of	death?
<u></u>											X	Yas Z□No	1 1/2	Yes 2□ No
Vital	ysiclan: The secondinate director, page	23	25. Was case refe examiner?	_	Hospital: منذ				Othe		ath (Check only o			
ō	\$ 00	<u> </u>	1 ☐ Yes 2 🗖 27. Menner of Dee		1 2 In		ER/Outpatient 28b. Time of		200	Indishig	Home 5 ☐ Resi			1)
5	Affar funer	5	1 Neturel	5 Pending	(Month	Dey Year)	Injury		28c. Injury Work		28d. Describe	now injury occu	irrea	
<u>s</u>	Attending r death.  Cotor: Aftai by the fune	20	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not b		ad turbing		М		res 2 □ No	20f Location /	Canada a and a land	D	/ Double March and
Division	or Attendati aftar deati Director: I in by the	Certification:	4 ☐ Homicide	determined	buildin	g, etc. (Speci	nome, farm, stree ify)	et, ractory	y, office		City or To		iber or mura	I Route Number,
_	letter surs lined	3	29a. Certifier	ATT COMMAND DE					. A. Ab A'	- 4.1 - 4.1				- 1
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	(Check only one)	1 ☑ Certifying Ph 2 ☐ Medical Exan	niner: On the bas and manne	sis of examina	ation and/or inve	stigation	, in my op	e, date and place inion, death occ	e, and due to the urred at the time,	cause(s) and m date and place	anner as st , and due to	ated. the cause(s)
	Within To the comple		29b. Signature and	title of certifier				290	c. License	number		29d. Date sign	ed (Month, I	Day, Year)
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	1.		30. Neme and a idi	ress of person who	1 Zl	of double (the	- 02-) (Time D	(Amin					1	104
			W. RAY	MOND ZHU		700 Ca	ATON AVE	ENLIE	= , B	ALTIMOR	RE. M	D 212	29	
	State Registra	-	31. Dete filed (Mor		32. Re	gistrar's Sign		fran	43					

		1 - For Stata Registrar	State of Mary	land / De		Health and	Mental Hy	giono	2004 2004	0690
The second secon	ysician Aedical	Decedent's Name (First, Middle, Last,  Eul Y	ung Chung				2. Date of De Month March	ath _Day	Year 2004	3. Time of Death
1	aminer eral	4a. Facility Name (If not institution, give FONKIN SQUAL) 5. Social Security Number 6. Sec. 219-70-9814	e Hospit	yrs. last birtho	ROSC ay) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		4c. Co	unty of Death	plece (State or Fore
Q		Usual Residence of Decedent  10a. State  10b. County  Maryland	100	c. City, Town o						10d. Inside City Limi 1 X Yes 2 □ N
h with the	at be notified	10e. Street and Number 930 Mace Avenue			10f. Zip Code 212	221		_	of What Cou	•
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-1 show	Examination of the Property of	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 255No If Yes, Give Year or Dates:	in U.S.	3. Was Decedent of I If Yes, specify Cub		pecify Yes or No o Rican, etc.)		Race - Ameri Black, White, ecify: AS	can Indian, , etc. ian
21215-0036 and within 72 hours aff giene.	r, the Medical E	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	16a. De (G	cedent's Usual Occup ive kind of work done e. DO NOT use retire	oation during most of wo d)	rking	16b. Kind	of Business/In	ndustry
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other then	event, the Be Con	12 17. Father's Name (First, Middle, Last)	4		Self Empl	7	ne (First, Middle,		wn Bus	iness
Maryland of 2 should be file lih and Mental Hy 27 is marked oth	traumatic	19a. Informant's Name/Relationship (Ty Chris Chung - Son	грө, Print)	11	ailing Address (Street Mace Avenu	and Number or Re				,
Baltimore, Dermit. Pages 1 an Department of Heal mportant: If item 2	ry or other	20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Ob. Place of Di cemetery,	sposition (Name of crematory or other pla	сө)	Date 9/04	20c. Locati	on-City or T	own, State
Balti permit. Departm Imports	eny inju once.	21. Signature of Funeral Service Licens			22 Name and Addre Gary L. Ka 7250 Washi	ess of Facility Aufman Fu	neral Ho	ome At	MMP.	
CB760, Wed Exami Physician and physician and	burial-transit ab prince a	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ASPICOTION DUO 10 (or as a cor	nsequence of):  Pain P  nsequence of):	i e ilmoni.	λ				Interval Between Onset and Death
Box eath cert	etached for use as the Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	3c. If yes, outcome of pro 1 Live birth 2 4 4 Pregnant at time 9 Unknown	Fetel death	3 □Ectopic pregnanc; 5 □ Other (specify) □	y		23d.	Date of deliver	ery Day Year
cords, P.O.  w requires that the de	<b>A</b>	Part II. Other significent conditions con	ntributing to death but not	t resulting in th	e underlying cause gru	en in Part I.		obacco use d		he cause of death?
Vital Reco	Q Q						24a. Was autop perfo 1  Yes		tb. Were auto prior to co death? 1  Yes	opsy findings availat impletion of cause of 2 No
of Vita Physician this certif	funeral director, page tion; To Be Com	1 183 2 2 110		2 ☐ ER/Outpa	The second second second second second	er: 4 Nursing H	th <i>Check onli o</i> ome 5□Resid		Other (Specif	<b>'y</b> )
Division of Vital Records, I or Attanding Physician: The law requires tarter death.  Director: After this certificate has been signe	ed in by the funera Certification;	27. Manner of Death  1  Natural 5 Pending investigation  3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Yee 28e. Place of Injury	At home, farm,	y Wor M 1□	yat k? Yes 2∐No		Street and Ni		al Route Number,
Division  To the Hoepital or Attant within 24 hours after deatt To the Funeral Director:		29a. Certifier 12 Certifying Phys	building, etc. (Sc sician: To the best of my ner: On the basis of exar	knowledge, d	eath occurred at the tir	ne, date and place	City or Tov	cause(s) and	manner as s	tated.
To the P within 2	completely fil	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date sig	gned (Month,	Dey, Year)
	State	30. Name an address of person who come of the come of	9 200 Fron	KIII S	quarell	ive Bo	-itimos	e mo	,2123	1

			For State		State of Ma	ryland /	-	artment of tificate o		Mental H		2001.	00000
			Registrar  1. Decedent's Name (First, I	diddle La	ct)		Cer	uncate o	Deam	2. Date of D	Reg. No	2004	U6908
	Physici	ian		VIIOUIO, La:	>t <i>)</i>	Q '				Month MARC	Da	y Yeer	3. Time of Death
	/Medic		Tekei  4a. Facility Name (If not insti	tution, aive	e street and number)	Coving	con	4b. City. Town	, or Location of De			2004 County of Death	4:33 P <sup>M</sup>
1	Examir	ier	124 CALVIN I					DUNDA				BALTIMORE	1
	Funeral		5. Social Security Number	6. S	ex 7. Age	(In yrs. last b	irthday)	If Under 1 Year Months Day	ar If Under 24 H				lace (State or Foreign try)
	Director		219-92-7665		□ M 2 7 5	33	Yrs.	MOTITIS Day	S Hours Mi	1-24	-71	Md	
	and w		Usuel Residence of Deceder 10a. State 10b. Co			10c. City, Tov	vn or Lo	cation				11	0d. Inside City Limits
	Aaryik f eho	5		altin	oro		dalk					, '	1√2 Yes 2 □ No
	28a-	Director	10e. Street and Number	атсти	ore	Durk	σατν	10f. Zip Code			10a. Cit	izen of What Coun	
	3a or	Ö	124 Calvin	Hill	Court			2122			_	USA	.,,.
	death ma 2	Funerai	11. Marital Status	11111	12. Was Decedent B	ver in U.S.	13. \	Vas Decedent o	f Hispanic Origin?	(Specify Yes or N		14. Race - Americ	
21215-0036	ges 1 and 2 should be tiled within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Mudical Exarts as finial by nutilised at	by	1 Never Married 2 ☐ 3 Widowed 4 ☐ Divo		Amed Forces? 1 □ Yes 2 □ N If Yes, Give X Year or Dates:	lo		Yes 2MX N	uban, Mexican, Pue o <i>Specify</i> :	эпо нісап, екс.)		Specify: Bla	
2-0	72 hc	Completed	15. Dec (Specify only h	edent's Ed	lucation de completed)	16a	. Deced	ent's Usual Occ	upation ne during most of w	rorkina	16b. K	ind of Business/Ind	lustry
21	han *	mpie	Elementary/Secondary (0-		College (1-4or 5	+)	life. L	OO NOT use reti	red)	oning .			
121	filed withi Hygiene. other than		12th grade 17. Father's Name (First, Mic	ddlo ( act)		S	ecre	tary	10 Mothada N	ame (First, Middle		aries	
Maryland	2 should be f and Mental b ie marked of raumatic ever	Be c		Jule, Last/	Cor	ington				ame ( <i>Fiist, Middi</i> amela	s, Maideri	Jone	6
2	should nd Me mark matic	은	Gary  19a. Informant's Name/Rela	tionship (1			o. Mailin	a Address (Stre	et and Number or I		ner City o		
S	and 2 sealth ar n 27 is ser trau		Gary Coving		Father				thern Par				21222
ē,	s 1 and 2 if Health item 27 i		20a. Method of Disposition			20b. Place o	of Dispos	sition (Name of natory or other p	(aca)	Date	20c. Lc	ocation - City or To	wn, State
Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 d Burial 2 ☐ Crema 14 ☐ Donation 5 ☐ Oth				-	. Pk.	. 1	10-04	Dans	allstown	FM
alti	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Ser	vice Licen	590)	TITING		Name and Add				ore, Md.	21202
<u> </u>	89 2 2 3		/eren/	-	nay			larch F.		1101 1	E. No	rth Ave	
	Physician /Medical		23a. Antl. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or comp List only	a	the death. Do	e	er the moder of d	ying, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions, if any, leading to immediate	- 1	b	Bon	سفر	I	Lower	troni			
	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	⋞	Due to (or as a	consequence	Of):						
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	1	c. Due to (or as a	consequence	of):						
68760,	siciar siciar siburi	dicai E		•	d								
	es F	edic			0.								
.O. Box	it the death certifii by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Inknown	t	23c. If yes, outcome of a light of the control of	2 ☐ Fetal death		Ectopic pregnan Other (specify)	су		2	23d. Date of deliver Month	y Day Year
Δ.	de de	by Ph	Part II. Other significant cor	nditions co	ontributing to death bu	t not resulting i	n the un	derlying cause g	iven in Part I.	23e. Did	tobacco u	se contribute to the	e cause of death?
rds	quires an sign uld be									1 🗆	Yes 2	No 3□ Proba	ably 4 Unknown
Records,	s been s been s shoul	Completed								24a. Was		24b. Were autop	sy findings available
Re	The lav ate has page 2:	E									psy ormed? 2 ☐ No	death?	pletion of cause of
Vital		Be C	25. Was case referred to me	dical					26. Place of De	eath Check only		100	20 140
of <	Physician: this certific ral director,	70	1XXes 2 No		Hospital: 1 Inpatier	t 2 ER/O	utpatient	3 DOA	ther: 4 🗆 Nursing	Home 5 ☐ Res	dence 6	Other (Specify,	AT SCENE
ion o	ling After fune	ertification;	100100111	estigation			Time of Injury		ury at ork? □ Yes 2 □ No	28d. Describe	how injury	y occurred	
Division		Certific	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide de	ould not be stermined	28e. Place of Inju building, etc.	ry - At home, fa (Specify)	ırm, stre	et, factory, office	•	28f. Location ( City or To	Street and wn, State)	d Number or Rural )	Route Number,
	To the Hospital or within 24 hours afte To the Funaral Dir completely filled in	edical	29a. Certifier 1 Cert (Check only 2 Med	tifying Phy icel Exem	ysician: To the best o liner: On the basis of and manner stat	examination ar	e, death id/or inv	occurred at the estigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) date and	and manner as sta place, and due to	ited. the cause(s)
	To the within 2 To the complete	¥	29b. Signature and title of ce	rtifier	lean )			29c. Licer	.M.E			a signed (Month, D ARCH 5,	ay, Year) 2004
	X		30. Name and address of per		completed cause of de	111 H	enn	Street	, Baltimo	re, Marv	land	21201	
	Sta	te	31. Date filed (Month, Day, Y	'ear)	32 Registra	's Signature							
	Registr	ar	MAR 0	8 200	4 Secure	's Signature	hone	est à					
DHI	MH 17 Rev 1/20	001				-	1	-		-			

ORIGINAL

ICI	A CURE	ION	T - For State Registrar		State of	Marylar			t of Hea		lental Hy	giene Reg. No.	2004	neand
	Physic		Decedent's Name (First, Mid     Alicia	dle, Last)	Α.		Cureto			<del></del>	2. Date of De Month FEB	ath Day	2004	3. Time of Death 2:24 P M
	/Medi Exami		4a. Facility Name (If not institut ST.AGNES HOS	-	eet and num	nber)	Carco	4b. City,	Town, or Loc	ation of Death	120.	4c. C	ounty of Death	2:24 5
¥, , , ,	Funeral Director		5. Social Security Number 212-65-9196	6. Sex	4 2 <b>X</b> F	7. Age (In yrs.	last birthday) Yrs.	If Under Months		Jnder 24 Hrs. ours Min.	8. Date of Birt (Month, Da 8-6-02		9. Birthp Coun	
	within 72 hours after death with the Maryland ene than "natural", or Items 23a or 28a-f show the Medical Exercises must be notified at	ector	Usual Residence of Decedent  10a. State 10b. Coun  Md.	nA		10c. Ci	ity, Town or Lo	more						0d. Inside City Limits  M☐ Yes 2 ☐ No
	ath with ti	rai Dire	10e. Street and Number 512 S. Bruns	swick	Ave.				21223			US		
980	ours after de ral', or Items Exercise re	by Funeral Director	11. Marital Status 1	arried	. Was Dece Armed For 1 ☐ Yes If Yes, Give Year or Da	<sup>2</sup> ₩ <sup>No</sup>	İ	Was Deced f Yes, spec 1 ☐ Yes 2		nic Origin? (Spe exican, Puerto pecify:	ecify Yes or No- Rican, etc.)		. Race - Americ Black, White, o pecify: Blac	etc.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked othar than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	(Specify only high Elementary/Secondary (0-12 Infant		tion completed) College (1-	4or 5+)	(Give life, l	dent's Usua kind of wor DO NOT us afant	e retired)	g most of worki		NA	of Business/Inc	lustry
Maryland	should be fill and Mentat Hy marked oth	To Be	17. Father's Name (First, Middle  Vardie			Curetor				Mona			Mackey	
	Tand 2 sho Health and tem 27 is m		Rochelly Mack		Sist		1000	Shel	lbanks	Rd.	Baltimo	ore, l		225
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other  21. Signature of Funeral Service	(Specify)	noval from S	State	Place of Dispo cometery, cren	natory or ot . Pk.	ther place)	3-9-0		Rand	dallstow	n, Md.
Ba	permit. Departr Importa		▶ , Glad	of 1	Van	~e_	M	larch	F.H. E	Cast ]	1101 E.	North	re, Md. n Ave.	21202
	Physician /Medical Examiner	)r	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, from leading to immediate.	st only one	Due to	chype	quence of):	er the mode	a or aying, su	en as cardiac c	r respiratory an	rest,		Approximate Interval Between Onset and Death
,09289	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last	c. d		or as a consec								
.O. Box 6	t the death certific by the attending p ached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	230	1 ☐Live bir	ome of pregna th 2 □ Feta ant at time of c wn	aldeath 3 ⊑	Ectopic pre Other (spe				230	d. Date of deliver Month	y Day Year
ords, P	w requires that been signed should be det	by	Part II. Other significant condi	tions contri	buting to dea	ath but not res	sulting in the ur	nderlying ca	iuse given in	Рап I.		bacco use		a cause of death?
Vital Records,		Completed										sy med? 2 🗆 No	prior to com death?	sy findings available indition of cause of
of Vit	Physician: this certific ral director,	To Be	25. Was case referred to medic examiner? tXX es 2 ☐ No				ER/Outpatien		A Dther: 4		(Check only or ne 5 ☐ Resid		Other (Specify)	10)
Division (	Attanding death. ctor: After y the fune	Certification;	3 Suicide 6 □ Coul	tigation	2/2 28e. Place o	(Day Year)	28b. Time of Injury  in Kn 2007  ome, farm, stre	M		2 No	28f. Location (S. City or Town	treet and N	feeter	. /
Ω	To the Hospital or I within 24 hours after To the Funeral Direct completely filled in b	edical Ce	29a. Certifier 1 Certify (Check only one)	ing Physic I Examine	ian: To the l	sis of examina	owledge, death ation and/or inv	occurred a restigation,	it the time, da	ite and place, a	and due to the co	ause(s) an late and pla	d manner as sta	ted. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certification	ier U	1/2	Xani	2	29c.	O.C.M		2	9d. Date s FEB.	igned ( <i>Month, D</i>	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
	18		30. Name and address of person	UKA	7	1	11 Pen		eet, B	altimor	e, Mary	land	21201	
Dist	Sta Registi		31. Date filed (Month, Day, Yea	/		gistrar's Signa	ature /	Sperk	· (a)					

are type of the model machine mile Ensure An oopie	S AIC I	-egrbie.	
State of Maryland / Department of Health and Mental H	lygiene	2001	nenia
Certificate of Death	Den Me	2004	00711

			1 - State Registrar	Ce	rtificate of Death	_	g. No.	0691
1	6.0		Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death
	Physici /Medi		MICHAEL JOSEPI		ASEM	FEBRUARY	29,2004	1:53 a M
	Examir	ner	4a. Facility Name (If not institution, give street and 434 MARTIN DRIVE	number)	4b. City, Town, or Location of Death		4c. County of Death	
		26.0	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	MILLERSVILLE  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	ANNE ARUN	
	Funeral Director		215 – 98 – 1966  Usual Residence of Decedent		Months Days Hours Min.	(Month, Day, 1	1967	place (State or Foreign ntry) MD
	death with the Maryland ims 23a or 28a-1 ehow r naist be notified at		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	a-1 el	ctor	MD ANNE ARUNDEL	MILLERS	VILLE			1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Cou	ntry?
	ath w	ľa	434 MARTIN DRIVE		21108		U.S.A.	
350	be filed within 72 hours after death with the Marylan ital Hygiene. d other than "natural", or Items 23s or 28s-1 show event, I'm Modical Exercitive mast be notified at	by Funeral	1 Never Married 2 Married 1 Never Married 1 Ma	d Forces? es 2 □ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1☐ Yes 2☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: WHI	etc.
9500-61212	within 72 hou ene. than "natura ne Medical E	Completed	15. Decedent's Education (Specify only highest grade complet  Elementary/Secondary (0-12)  Collect	ed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ing 16	6b. Kind of Business/Ir	
	filed wit Hygiene other tha	Com			LE SPLICER		TELEPHONE	
land		To Be	17. Father's Name (First, Middle, Last) THOMAS JOSEPH CASEM		18. Mother's Name	<i>(First, Middle, Ma</i> PERILLO	,	
Mary	s 1 and 2 should I Health and Men Item 27 ie marke other traumetic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Rura	l Route Number, (	City or Town, State, Zip	Code)
e, E	and sealth m 27		MRS. CHARLANN CASEM /		MARTIN DRIVE MIL	LERSVILL	E, MD 2110	
0	Pages 1 nent of H int: If ite		20a. Method of Disposition  XX Burial 2 □ Cremation 3 □ Removal fr  4 □ Donglion 5 □ Other (Specify)	20b. Place of Dispo cemetery, crei	natory or other place) MAR 4	late 20	OLINGWILL C	
galtimor	it, Pa		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature III – uneral Service Licensee		, 2004		OWNSVILLE,	
n n	permit, Pages Department of t important: If its any injury or of once.		Market Vision Service Literates	- molla0 1	Name and Address of Facility SIA SECOND AVENUE GL	IGLETON F .EN_BURNI	UNERAL HOM E, MD 210	E, P.A. 61
	Physician /Medical Examiner	er	restulking in death)  Due	on each line.	ot wound of	. ,		Approximate Interval Between Onset and Death
68/60,	death certificate be executed e attending physician and id for use as the burial-transit	Medical Examin	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due	to (or as a consequence of):				
	D D D	Physician/Med	in the past 12 months?	outcome of pregnancy re birth 2 Fetal death 3 egnant at time of death 5 known	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
cords, r	law requires that the de as been signed by the a 2 should be detached	by	Part II. Other significant conditions contributing t	o death but not resulting in the ur	nderlying cause given in Part I.		cco use contribute to the	ne cause of death? ably 4 []Unknown
ב	a 5 C/	Completed				24a. Was an autopsy performe 1 X Yes 2	d? prior to co	psy findings available inpletion of cause of 2 No
N E	ician: certific ector,	Be	25. Was case referred to medical examiner?  Was a 20 No. Hospital:	THE -	26. Place of Death			
5	Phys rthis raldir	1.	VVies 5 10	☐ Inpatient 2 ☐ ER/Outpatien ate of Injury 28b. Time of		ne 5 Residence 8d. Describe how	e 6 Other (Specify	1) At youre
5	nding th. : Afte	ıtlon		fonth, Day Year) Injury	28c. Injury at Work?  ↓ M 1 □ Yes 2 🔊 No	Subject	Δ.	inself
DIVISION OF	or Atter iter dea iractor n by the	Certification:	3 Suicide 6 Could not be	ace of Injury - At home, farm, stre illding, etc. (Specify)	eet, factory, office	8f. Location (Stree	et and Number or Rura State) 434 Ma	I Route Number
_	pital ours a leral [		29a. Certifier 1 ☐ Certifying Physicien: To		occurred at the time, date and place, a	Hillersvill	e mD	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	<b>ledical</b>	(Check only 2 X Medical Examiner: On the one) and m	e basis of examination and/or invariance stated.	restigation, in my opinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
	To To Con	Z	29b. Signature and title of certifier  M. M. I	>	29c. License number  OCME		Date signed (Month, 2)	
/	10		30. Name and address of person who completed c $\omega \sim \omega$		Print) L Penn Street, Bal	timore, M	Maryland 21	201

State Registrar

31. Date filed (Month, Day, Year)
MAR 0 8 2004

32. Registrar's Signature

best

			For	State of Ma		epartment of I		lental Hygi	ene		
_			1 - State Registrar		(	Certificate of	Death	Re	g. No. 2 (	104	06911
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	A. (	Carro	//		2. Date of Death Month MARCIT	Day S	Year 2004	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s  SAINT A THE S	1 .	HCARE		or Location of Death		4c. County		
	Funeral Director		009 07 0711	7. Age	(In yrs. last birth			8. Date of Birth (Month, Day,		·	ace (State or Foreign try)
	ith the Maryland or 28e-f show	or	Usual Residence of Decedent  10a State  10b. County  CALTIN	10rp	10c. City, Town	or Location,				10	Od. Inside City Limits
	ith with the I 23a or 28e-	Funeral Director	10e. Street and Number	Choice	10.	10f. Zip Code	38	10	g. Citizen of V	Vhat Count	try?
36	s I and 2 should be filed within 72 hours after death with the Maryland I Heatth and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28e-f show other traumatic event, the Mudical Examiner must be notified at	by Funera	11. Marital Status  1 Never Married 21 Married  3 Widowed 4 Divorced	12. Was Decedent E Armer Forces? 1 DYes 2 N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		e - America ck, White, e	
Maryland 21215-0036	hin 72 hou 3. In "natural Medical E	Completed b	15. Decedent's Educ (Specify only highest grade	ation	26	ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	during most of working	ng	6b. Kind of Bu	1 0	,
nd 21	permit. Pages 1 and 2 should be filed withir Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Modes.	Be Com	17. Father's Name (First, Middle, Last)	3yrs	59	r. OF Gu	18. Mother's Name		ecleric aiden Syman		out.
aryla	2 should be and Mental is marked c	Tol	19a. Informant's Name/Relationship (Type	Arroll pa, Print)	19b. I	Mailing Address (Street	and Number or Rura	Route Number,	VUTTS City or Town,	State, Zip	Code)
ē, ⊼	s 1 and 2 f Health a item 27 is other trau		20a. Method of Disposition	OII UR.	20b. Place of D	S Nagaer	n Choice	Ln.	Oc. Location -	City or Tov	wn, State
Baltimore,	t. Pages rtment of I rtant: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Counsi	crematory or other pla	metery 3-11	-04 C	rownsi	ille,	MD
Bal	permit. Departi Import any inj	5 13	21. Signature Muneral Avic Licens	_		San P. Ma	rch FIH a	10 Fredh	ilton P	ass E	Balto, mo alas
	Physician		23a. Pain. Enter the disease, or complice shock for heart failure. List only on Immediate Gause (Final disease or condition	e cause on each lin	θ.	enter the mode of dyir					Approximate Interval Between Onset and Death
77	/Medical Examiner		resulting in death)	Due to (or as a	consequence of)						
2	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of)	:					
CH R 68760,	rcate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as a	consequence of)						-
_	eath certitica attending ph		IF FEMALE:	Bc. If yes, outcome of	of pregnancy						
きかいをはり Records, P.O. Box	The law requires that the death certit tle has been signed by the attending page 2 should be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 ☐ Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _			23d. Date Mor	e of delivery	y Day Year
\$ ₩\\$\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	wrequires that the de been signed by the a should be detached t	ed by PI	Part II. Other significant conditions conf MYDC(A(2D1 A)	tributing to death bu	t not resulting in the	ne underlying cause giv	en in Part I.				cause of death?
⊗ I Reco		Completed						24a. Was an autopsy performe	ed? d	Vere autops rior to compeath?	sy findings available pletion of cause of
/ita	cian ertifi ector	Be	25. Was case referred to medical examiner?	-			26. Place of Death				
of	hys his	5. To	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ospital: 1 Ninpatien 28a. Date of Injury	t 2 EP/Outpa		4   Naising Hon	e 5 ☐ Residend 8d. Describe how			
⇔ io	Attending I r death. sctor: After by the funer	atlor	1) □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	Year) Inju	ry Wor	k? Yes 2 □ No	od. Describe flow	injury occurre	id .	
E & Division of Vital	tel or Attendir rs after death. al Director: Af ed in by the fu	Certification;	3 Duicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm (Specify)	, street, factory, office	2	8f. Location (Stre City or Town,	et and Numbe State)	r or Rural I	Route Number,
NAME	To the Hospitel or within 24 hours after to To the Funeral Dire completely filted in b	edical	29a. Certifier (Check only one) 1 Certifying Physical Cartifying Chysical Examin	ician: To the best of er: On the basis of and manner stat	examination and/o	eath occurred at the tin r investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the caud d at the time, date	se(s) and mar and place, a	ner as stat	ted. he cause(s)
	withii To the	N	29b. Signature and title of certifier	7	1.	29c. Licens			. Date signed		
	111		K. Clust-	herson	wil		20103	M.	HISCH	5	2004
	51		30. Name and address of person who con		ath (Item 23a) (Ty	pe, Print)	AUEMUE	BALT	(WOV	U 315	as.
	Sta Registra		31. Date filed (Month, Day, Year) MAR 0 8 2004	2. Registra	's Signature	refe )					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) MAR. JOHN A. CONNELLY 2004 **Physician** 1:30AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore County
If Under 1 Year | If Under 24 Hrs Baltimore 7156 Greenwood Avenue 8. Date of Birth Oct. 12, 1922 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours XXXM 2 F 81 Maryland 214-14-1008 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County t of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23e or 28a-f ahow or other traumatic event, the Medical Examinat must be notitied at 1 ☐ Yes 2 X No Directo Maryland Baltimore Baltimore County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 7156 Greenwood Avenue USA Completed by Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give WW 11 1 Never Married 2 Married Specify: White 1 ☐ Yes XX No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dye Maker C. & J. Embossing Co. 10 yrs. N/A Pages 1 and 2 should be filed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Francis Connelly Elizabeth Blatchley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9704 Oakdale Ave. Baltimore, Md. 21234 (Son) John A. Connelly, Jr. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1) Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 3-8-04 permit. Page Department of Important: If any injury or Baltimore, Md. ⁴ 4 □ Donation 5 □ Other (Specify) <sup>22</sup>Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 21. Signature of Funeral Service Licensee Part i. Enter the disease, or complications that cause it is death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DOCK; Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or a a consequ **Examiner** COURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit Due to (or as a consequence of) attending physicien Completed by Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year jo in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown 23e. Did tobaçco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. be 1 Yes 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 2□ No certificate 1 Yes 2 No 1 Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes Medical Certification: To this the funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Hospital or Attanding 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after deati To the Funerel Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Ę 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 29c. License numbe 2 o completed cause of death (Item 23a) (Type, Print) 30. Name and address-

State Registrar 31. Date filed (Month

0 8

2004

Maryland 21215-0036

Baltimore,

of Vital Records, P.O. Box 68760,

Division

32 Registrar's Signature

2/22

			1 - For State Registrar	State of Marylar	d / Depa		ealth and l	•		20	
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last Ronald Cornet 4a. Facility Name (If not institution, give	t		4b. City, Town, or Baltym		2. Date of D Month FEB	Death Day ಫೆ ಲ		ar 1:02 P M
	Funeral Director		5. Social Security Number 6. Se	/ - /	last birthday) Yrs.	If Under 1 Year   Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth Pay, Year) + 19	45 9.	Birthplace (State or Foreign Country)
	he Maryland 8a-f show offfied at	Director	10a. State 10b. County MD	10c. Cit	y, Town or Lo Balti	more					10d. Inside City Limits 1 🏋 Yes 2 🗆 No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "neturel; or Items 23a or 28a-f show amy injury or other treumatic event, It's Medical Examiner must be multified at Ance.	by Funeral Dire	10e. Street and Number  1404 Copper Street  11. Marital Status  1 X Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	2 t #6  12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	'	Was Decedent of His f Yes, specify Cuban	1223 panic Origin? (Si, Mexican, Puerto	pecify Yes or No Rican, etc.)		14. Race - A	Country?  USA  merican Indian, /hite, etc.  White
Maryland 21215-0036	within 72 hoursine.	Completed b	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation	(Give life. I	lent's Usual Occupat kind of work done du DO NOT use retired)	ion rring most of wor	king	16b. Ki	nd of Busine	ss/Industry
yland 2	ould be filed of Mental Hygie arked other fatic event, in	To Be Co	17. Father's Name (First, Middle, Last)	IIK.		janitor unk	18. Mother's Nam	ne (First, Middl	e, Maiden	taver Sumame)	ns unk
e, Mar	1 and 2 sho Health and Iem 27 is mu		19a. Informant's Name/Relationship (Ty University Speci	alty Hospital	601 S	g Address (Street ar 5. Charles sition (Name of	Street	ra <i>l Route Numi</i> Baltim Date	ore,	MD 2	e, Zip Code) 1230 or Town, State
Baltimore,	permit. Pages Department of i Importent: If It any injury or o		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	lemoval from State in state	emetery, cren	Name and Address	)   				
ı	Physician /Medical Examiner		23a. Int. Enter the disease, or complish ck, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	callin's that caused the death in cause on each line.	Ba. Do not ente	Itimore of the mode of dying,	MD 2120 such as cardiac	1 or respiratory		timore	Approximate Interval Between Onset and Death
	ate be executed hysician and the burial-transit	ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):						
O. Box 68	it the death certifica by the attending ph tached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 🗆	Ectopic pregnancy Other (specify)			2	3d. Date of o	delivery Day Year
ords, P	faw requires that the as been signed by th 2 should be detache	ed by Pr	Part II. Other significant conditions cor	, they notwom	law)		in Part I.			se contribute	to the cause of death? Probably 4 Dunknown
<u> </u>	The ate h page	Completed		ve vent dop ental Retardas	anda/			24a. Was auto perfe 1 🗆 Yes	psy ormed?/	death	autopsy findings available o completion of cause of es 2 De
	ng Phy fter this ineral d	ertification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 I	ER/Outpatient 28b. Time of Injury	3 DOA Other: 28c. Injury a Work?	4 [ Indising the		dence 6		pecify)
DIVISION	pital or Affe	OL	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	)			City or To	w⊓, State)		Rural Route Number,
•	I o the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one)  29b. Signature and title of certifier	ician: To the best of my knowner: On the basis of examinat and manner stated.	viedge, death	29c. License r	ion, death occur	ed at the time,	date and p	signed (Mo	as stated. ue to the cause(s)  nth, Day, Year)
			30. Name and address of person who co	mpleted cause of death (Item    Neshibe   60	23a) (Type, F		+1ms				1430
	Sta Registra		31. Date filed (Month, Day, Year) MAR 0 8 2004	32 Registrar's Signat		all 3					

DHMH 17 Rev 1/2001

Ronald Connoth

			1 - For State Registrar	State of Maryland		artment of F		and Menta	al Hygie	-20	104	06914
N. W.	Physici /Medic		1. Decedent's Name (First, Middle, Last, Rowland	Delfox				Ma	ite of Death onth rCh		2004	3. Time of Death 6:30 A M
}	Examin	er	4a. Facility Name (If not institution, give 901 Buckingham Dr	ive		4b. City, Town, o	ville			4c. County Queer	n Anne	e County
6.	Funeral Director		5. Social Security Number 6. Security 127–20–5029	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. (M	te of Birth onth, Day, Ye 26, 1	929	9. Birthpla Count New	ace (State or Foreign ry) York
	Maryland -I show	tor	10a. State Maryland Queen An	no	Town or Lo teven	cation sville					10	od. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28a	Funeral Director	10e. Street and Number 901 Buckinham Driv	e		10f. Zip Code 21	666		-	Citizen of W		•
036	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be multified at Once.	ρ	11. Marital Status  1 Never Married 2 Marned  3X Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? ↑ Cover 2 □ No If Yes, Give Year or Dates:	ĺ	Was Decedent of H f Yes, specify Cub	dispanic Ori an, Mexican Specify:	gin? (Specify Y i, Puerto Rican,	es or No- etc.)		e - America k, White, e Whi	etc.
21215-0036	d within 72 ho plene. r than "natur the Mudical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	(Give life. I	dent's Usual Occup kind of work done DO NOT use retire med Cour:	during mos d)	t of working		Securi		ustry
Maryland (	uld be filed Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) James George Delfo	x				er's Name <i>(First</i> el Johnt		den Sumam	Θ)	
	and 2 sho salth and I n 27 is me er traume		19a. Informant's Name/Relationship (T) Peter Delfox - Son		901 B	ng Address (Street uckinghat	n Driv					code) and 21666
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Balt	permit Depare Import any in		21 Sign for of Funeral Sews Lines	Clade MOIL	42 Pr 21	adley-Asi 34 Willo	nton-li w Spri	Matthews ing Road	Funer Dunc	ral Ho dalk,	me, I Maryl	Inc. Land 21222
	Physician /Medical Examiner	Ĺ	23a Part 1. Entartité disease, or coma shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that aused the death. The course on each line.  Might ast  Due to (or as a conseque  Might ast	atic	liver (	ag, such as	cardiac or resp	ratory arrest,			Approximate Interval Between Onset and Death MON #
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<u> </u>	luires that n signed b ild be deta	þ	Part II. Other significant conditions co	ntributing to death but not resul	ting in the u	nderlying cause giv	en in Part I	. 23	3e. Did tobac	. /		e cause of death?
Division of Vital Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed							ta. Was an autopsy performed 2 2	12/ G	rior to com leath?	sy findings available apletion of cause of
Vita	sician: Th certificate rector, pag	o Be (	25. Was case referred to medical examiner?  1  Yes  2  70	Hospital:	B/Outseties	it 3□ DOA Ott	100	of Death (Che		6 COth		
ion of	Attending Physician: r death. sctor: After this certific by the funeral director.	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injui Wo		28d. D	escribe how i			
Divis	P = E	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, office			cation (Stree ty or Town, S		er or Rural	Route Number,
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	within To Market	Σ	29b. Signature and title of certifier	101	^	29c. Licens	o number	53	29d.	Date signed	(Month, D	2004
	18		30. Name and address of pers. Williams	moleted cause of death (Item :	23a) (Type,	Print Point T	3d. S.	te 107	Stor	ensvi	10	MD 211dde
	Sta Regist		31. Date filed (Month, Day, Year)  MAR 0 8	32. Registrar's Signatus	Ire A	Sparte	<b>B</b>			<u> </u>	15	

			For State Registrar	State of I	Maryland / Dep Ce	artment ertificate					06915
	Dhusisi		1. Decedent's Name (First, Midd	le, Last)					2. Date of De Month	Day Ye	3. Time of Death
	Physici /Medic				YE					04 2004	3:45 A M
	Examin	er	4a. Fecility Name (If not institution		er)			ocation of D	eath	4c. County of (	UNDEL CO.
			GENESIS SEVER		Age (In yrs. last birthda			PARK	Hrs. 8. Date of Bir		
	Funeral Director		213-32-8185	1□ M 21√2F	76 Yrs.				Vin. (Month, Da		Birthplace (State or Foreign Country) Virginia
- Ar			Usual Residence of Decedent			1			April	05 1927	
	nytan how		10a. State 10b. County		10c. City, Town or						10d. Inside City Limits
	Ba-1-	cto		Arundel Co	· rasa	dena					1 Tyes 2 No
	d within 72 hours after death with the Maryland jeen. I then "naturel", or Items 23a or 28a-f ehow the Modical Examinational be notified at	Funeral Director	10e. Street and Number 7750 Meadow R	nad		10f. Zip C	ode 211	122		10g. Citizen of Wha	
	s 23s	eral		12. Was Decede	nt Ever in IIS 13	Was Deceder			2 (Specify Yes or No	- 14. Race -	American Indian,
	Item Item	Į,	11. Marital Status 1 ☐ Never Married 2 ☐ Mai	Armed Force		If Yes, specify	Cuban,	Mexican, P	? (Specify Yes or No uerto Rican, etc.)	Black, \	White, etc.
036	urs al	Ď	3 ₩ Widowed 4 Divorce	If Yes Give .	(L	1 □ Yes 2 t	No s	Specify:		Specify: W	hite
21215-0036	72 ho	Completed	15. Deceder	nt's Education est grade completed)	16a. Dec	edent's Usual ( re kind of work DO NOT use	Occupation	on ring most of	working	16b. Kind of Busin	
21	를 교육	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)					of Educ	undel Board
	filed with Hygiene ther the		10 17. Father's Name (First, Middle,	0	Ct	stodiar		8 Mother's	Name (First, Middle,		
Maryland	d la la la la la la la la la la la la la	Be c	Leonard	Gilbert			,		inche		naker
7	s 1 and 2 should I Health and Men item 27 is marke other traumatic	2	19a. Informant's Name/Relation:	ship (Type, Print)	19b. Ma	iling Address (5	Street and	d Number o	r Rural Route Numbe	er, City or Town, Sta	te, Zip Code)
	allth a		Larry A. Dye	(So	n) 775	O Meado	ow Ro	oad, F	Pasadena,	Md. 21122	
Je,	of Health of Health fitem 27 r other tr		20a. Method of Disposition	4 2 3	20b. Place of Dis	position (Name ematory or other	of er place)		Date	20c. Location - City	y or Town, State
E	Pages nent of int: If it iry or o		1√2 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3		Glen Hav			1 Pk.0	03/08/04	Glen Bur	nie, Md.
Baltimore,	permit. Pages Department of Important: If i eny injury or one		21. Signature of Funeral Service	Licensee	.11)	Address o	of Facility Polivi	niak Funer	al Home P	.A.	
0.1	70F 2		phil)	19 M	MUV	i Mot	untair	n Road, Pa	sadena, M	ld. 21122	
			23a. Sart 1. Enter the disease, of shock, or heart failure. Lis	r complications that cause t only one cause on each				Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	cciden	<u> </u>	years					
	Examiner			Due to (or	as e consequence of);						
	4	er	if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequence of):						
	d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>.</b>							
o,	a exectan an		resulting in death) Last	Due to (or	as a consequence of):						
8760,	death certificate be executed e attending physician and id for use as the burial-transit	lical		d							
x 68	leath certificat attending phy i for use as th	Physiclan/Med	IF FEMALE:	23c. If yes, outcor	no of prognagory			25-7		TES - 1000 - 100	
Вох	attenc for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	☐Ectopic preg				23d. Date of Month	Day Year
P.O.	that the de led by the detached	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown		Cities (spec					
	The law requires that the ate has been signed by th page 2 should be detache		Part II, Other significant conditi	ons contributing to death	but not resulting in the	underlying cau	se given i	in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
rds	w requires been sign should be	ed by	typerte	nsion					_ 101	/es 2□No 3□	Probably 4 Dunknown
Vital Records,	aw re is bee 2 sho	Completed	01						24a. Was		e autopsy findings available to completion of cause of
Ä	The tav	E							perfo 1 ☐ Yes	rmed? deat	h?
ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?						Beath (Check only o	ne)	
Mann	sin dir	္ရ	1 ☐ Yes 2 ☐ No		atient 2 ER/Outpati		Other:	4 Wursir	ng Home 5 Resid		Specify)
n c	ing P	lon:	27. Manne Death 1 V atural 5 ☐ Pendi		njury 28b. Time Day Year) Injury	of 280	. Injury at Work?	t s 2 ⊡No	28d. Describe h	now injury occurred	
Division	death death ctor:	cat	3 Suicide 6 Could		Injury - At home, farm,			5 2 NO	28f. Location (5	Street and Number o	r Rural Route Number,
<u>^</u>	after Direction by	Certification;	4 ☐ Homicide determ	building,	etc. (Specify)	wood, ladioly, c	,,,,,,		City or Tov		
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral		(Check only 2 Medica	ng Physician: To the be Examiner: On the basis	of examination and/or						
	thin 2 the the mplet	Medical	one) 29b. Signature and title of certific	and manner	stated.	29c. l	icense n	umber		29d. Date signed (M	fonth, Day, Year)
	Mil V		255. Old later and little of Certifier	12	- m		(fig.				
~	6		30. Name and address of person	who completed cause of	of death (Item 23a) (Tun	a Print)		00	100	0 /	aucy
			Cenniter Ki	edinar	- 8601 Ve	teran	st	hus.	Millers	ville 1	-2004 MD 21/108
	Sta	ite	31. Date filed (Month, Day, Year	As .	strar's Signature		-	0			
	Registr	ar	MAR 0 8 2	004 Alesta	IF Ago	ale.					

			1 - State Registrar	Department of Health and M Certificate of Death	Reg	.No. 2004 069
	hysicia		1. Decedent's Name (First, Middle, Last) William F. Dahlke		2. Date of Death Month	Day Yeer 3. Time of Dea
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	March 5	2004 8:20 A 4c. County of Deeth
			Brightview Assisted Living Ctr.	Rossville		Baltimore
	ineral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthplace (State or For Country)
Dir	ector		161-16-8280	Yrs.	Jan. 3, 1	1917 Maryland
yland	MO T		10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Li
e Mar	a-f s	ctor	Maryland Baltimore	Rossville		1 □ Yes 2√
Aith th	Le no	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
eath v	na 23e	erai	8100 Rossville Blvd.  11. Marital Status 12. Was Decedent Ever in U.S.	21236		U.S.A.
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene.	r flan	Completed by Funeral	Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc.
Maryland 21215-0036 d 2 should be filed within 72 hours aft and Mental Hygiene.	Era	i by	3 X(Widowed 4 □ Divorced If Yes, Give Year or Dates: WW II	1 ☐ Yes 2 🛣 No Specify:		Specify: White
22 h	nato	etec	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	ng 16	b. Kind of Business/Industry
Within With	than than	шр	Elementary/Secondary (0-12) College (1-4or 5+) (Unknown)	Dispatcher	1	Manufacturing
Hygie	ent, it	e Co	17. Father's Name (First, Middle, Last)		(First, Middle, Mai	
land be tental	ic ev	To Be	John Dahlke	Lena	Gerstei	
ary show	umat		19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Rura	l Route Number, C	ity or Town, State, Zip Code)
and 2	n 27 I		Mrs. Lillian Karl (daughter)	10 Hedgeford Ct., Bal	timore, 1	MD 21236
Ore	or oth		1 V Burial 2 Cremation 3 Removal from State Cemeter	y, crematory or other place)		c. Location - City or Town, State
Baltimore, Department of Hear	jury o		*4 □ Donation 5 □ Other (Specify) Holly f	Hill Mem'l Gard. 3/8/		altimore, Maryland
Bal Sermit	any in		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sch		
		- 1	23a Part 1 Enter the disease or complications that caused the death. Do o	9705 Belair Rd., B		
			23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Immediate Cause (Final	1		Approximate Interval Between Onset and Deat
Physi /Med	ician dical		disease or condition resulting in death)  a. Due to (or as a consequence of the control of the c	tote Cancer		Mark
Exam	niner			n):		
1000		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	of):		
acuter	trans	Examiner				
760, te be executed	Durial	cal Ex	Due to (or as a consequence of	of):		
687 ificate	s the t		d			
vision of Vital Records, P.O. Box 68 Attending Physicien: The law requires that the death certificat r death. actor: After this certificate has been signed by the attending phy	been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
Geath death	d for	icia	in the past 12 months?  1 Yes 2 No 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
or at the	tache	hys	9 ☐ Unknown			
S, I se that	pe de	by F	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death
ord requir	pinor	ted			1 Tes	2 No 3 Probably 4 Unkno
Division of Vital Records, P.O. to Attending Physicien: The law requires that the datter death.  Director: After this certificate has been stoned by the	20	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause
Vital Re	, pag				performed 1 ☐ Yes 2 🗖	? death?
Vita vicien certif	al director, page	o Be	25. Was case referred to medical examiner?	26. Place of Death		
Phy of	aral di	<b>⊢</b> ⊧	1 Inpatient 2 ER/Out	to make the same of the same o	ne 5 Residence 8d. Describe how in	6 Other (Specify)
On Iding	fune	ţi		ime of 28c. Injury at 2i jury Mork?  M 1 ☐ Yes 2 ☐ No	bd. Describe now in	ijury occurred
ViSi Atter	by th	Certification;	3 Suicide 6 Could not be		8f. Location (Street	and Number or Rural Route Number,
Dir	i be	Cert	4 Homicide building, etc. (Specify)		City or Town, St	rate)
Division of  To the Hospital or Attending Physical in 24 hours after death.  To the Funeral Director: After this	completely filled in by the funer	edicai	29a. Certifier (Check only (Ch	death occurred at the time, date and place, ar	nd due to the cause	e(s) and manner as stated.
To the H within 24 To the F	nplete	ledi	one) and manner stated.	vor investigation, in my opinion, death occurred	d at the time, date a	and place, and due to the cause(s)
0 = 0	9 9	Σ	29b. Signature and title of pertifier	29c. License number	29d.	Date signed (Month, Day, Year)
18.7	V		1 4 12	245 971		) 5 04
F ≥ F	A 1		30. Name and address of person who completed cause of death (Item 23a) (TDr. M. R. Rahnama, 9512 Harford Re		221	/
	0		VILO MO NO NUMBURA, 7012 HUZAUZA KA	u. Duximano MD 717	3/L	
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ar, buccanore, mb 272	.54	
4	Ø Stat egistra			a., Successore, Mr 212	.54	

04- cri	-01577			Ple	ase Type								•		_	le.		
CII			1 - State Unper Registrar	nd Item#	Stat <b>23a-b,Part</b>	e of M . $\Pi$ , :	larylan 27 <b>,</b> Per	d / Depa MEG836	artmer H <b>A</b> IO	nt of H Manager i	lealth Death	and N	Mental H	ygien Reg. No	- 24	04	06	917
7	Physic	22	Decedent's Nam	ne (First, Midd	dle, Last)								2. Date of D	eath Da	ıv \	rear	3. Time o	Death
100	Physici /Medi		RHAMIA	S. D	ODSON				,				March	02		004	8:07	АМ
	Examir	ner	4a. Facility Name (					<b>.</b>			Location	of Deeth			. County of	Death		
			Universi 5. Social Security I		MaryLand 6. Sex	-				Ltimo		r 24 Hrs.	9 Data of B		N/A	o Birth I		
}	Funeral Director		218-57-	0723	1 M 2		3 ge (in yrs. i	Yrs.	Months		Hours	Min.	8. Date of B (Month, D 05-18	Dav. Year.	00	9. Birthpli Count M	ace (State of try) ID	or Foreign
	and		Usual Residence of 10a. State	10b. Count	у		10c. City	y, Town or Lo	cation							10	d. Inside C	ity Limits
	the Marylan 28a-f show	ō	MD	M	/A			D	ALTI	MODI								2 No
	the 28a	rec	10e. Street and Nu		/ A			Б	10f. Zir		ن			10g. Ci	tizen of Wh	nat Count	11	
	ath with 23a or	Funeral Director	2607 FA	TRVTE	W AVE					21	215				USA	1		
	death ms 2	nera	11. Marital Status	TKVID	12. Was		Ever in U.	S. 13.	Was Dece			rigin? (Sp	ecify Yes or N Rican, etc.)	lo-	14. Race -	America		
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Exentinet must be revitified at	þ	1 🔀 Never Man 3 🗆 Widowed		rried 1 📑	ed Forces: Yes 2√2 s. Give or Dates:			ir Yes, spe 1 ☐ Yes		Specify		Hican, etc.)		Black, Specify:	White, e	ACK	
5-0	"natural",	etec	(Spe	15. Decede	nt's Education est grade comple	ited)		16a. Dece	dent's Usu kind of wo	al Occup	ation	st of work	ina	16b. K	(ind of Busi	ness/Ind	ustry	
2121	filed within Hygiene. Sther than "other th	Completed	Elementary/Sec			ge (1-4or	5+)	life.	N/A	se retired	()				I/A			
pu	be file d oth	Be	17. Father's Name	(First, Middle	, Last)						18. Moth	er's Nam	e (First, Middle	e, Maider	Sumame)			
Maryland	2 should be filted withir and Mental Hygiene. is marked other than aumatic event, I'm M	70	ANTOIN 19a. Informant's N			)		19b. Maili	ng Address	(Street			SMIT		or Town, St	ate, Zip (	Code)	
	1 and 1 Health em 27		SHEILA		N, GRAN	IDMO'					EW_		B, BA					
Baltimore,	0 0		20a. Method of Dis 1 □ Burial 2 4 □ Donation	Cremation	3 □Removal f	from State		lace of Dispo emetery, crei JNT Z	natory or o		e)	3-10	) – 0 4		ocation - Ci		vn, State	
Balti	permit. Pag Department Important: I any injury o		21. Signature of F	uneral Service	Licensee	vel	la						WELL					
100	Physician /Medical Examiner inial-transit	Examiner	23a. Part1. Enter shock, or het Immediate Cause disease or condition resulting in death)  Sequentially list of any, leading to incause. Enter Und. Cause (Disease or that initiated event resulting in death)	onditions, mmediate erlying s	a. Du Du Cc.	mplica e to (or as wn's S	ine.	of Compuence of):									Approximat Interval Bet Onset and I	ween
x 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE:		d		of pregna								204 5-1-1			
P.O. Box	that the death- led by the atten- detached for u	hysician	23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months? ☐ No	1 □ L 4 □ P	ive birth	2 Fetal t time of de	death 3	Ectopic pr Other (sp						23d. Date of Month		•	Year
	w requires that been signed should be del		Interstiti			to death b	out not resu	ilting in the u	nderlying c	ause give	en in Part I	1.	m	tobacco i	use contribi		cause of d	
Vital Records,		Completed by	-										24a. Was auto perf 1X Yes	s an opsy ormed? 2 \( \) No	prid	or to com:	sy findings a	available ause of
ita	sician: Th certificate irector, pag	Bec	25. Was case references	rred to medic	al						26. Place	e of Death	(Check only					
of V	S . S . D	10	1X Yes 2□	] No	Hospital:	1 🗌 Inpatio	ent 2 🔀 i	ER/Outpatier	t 3 DC	Othe	or: 4 □ Nu	ursing Ho	me 5 Res	idence	6 Other	(Specify)		
Division o	ding h. After fune	Certification:	27. Manner of Dea 1 Natural 2 Accident 3 Suicide 4 Homicide	5 ☐ Pendi invest 6 ☐ Could	not be 28e. F	Month, Da	jury - At ho	28b. Time of Injury	М		at ? Yes 2 🗆	No	28d. Describe	(Street an	d Number	or Rural	Route Num	ber,
Ō	pital or ours aft eral Di filled in		29a. Certifier (Check only	1 Cartifyi	ing Physician: T	o the best	of my know	wledge, death	occurred	at the tim	e, date ar	nd place,	City or To	cause(s)	and mann	er as stat	ted.	
	To the Hos within 24 h To the Fur completely	Medical	one)	Xwadica	I Examiner: On the and	manner st	ated.	ion and/or in	restigation	, in my op	inion, dea	ath occurr	ed at the time.	, date and	1 place, and	due to t	ne cause(s	) 
	To the within 2 To the Complet	Σ	29b. Signature and	tipe of certifi	er	M	1		290	. License	number C.M.	E.			te signed <i>(f</i>			
			30. Name and add	ress of person	who completed	cause of c	leath (Item			n St	reet	, Bai	Ltimore					
	Sta Registr	- 4	31. Date filed (Mor	nth, Day, Year	) 3	2. Registr	ar's Signat	to A	oork.	2/								

Registrar DHMH 17 Rev 1/2001 MAR 0 8 2004

Amend Item #9, 10a f, 17, 12, 17, 18, 19a b, 20a c, 22 per 1h G629 371 Legible tas
State of Maryland / Department of Health and Mental Hygiene 06918 Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month February **Physician** 328 PM 20021 James Duncan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hosaital BRITIMORE Speciality UNIVERSITY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept 16, 1965 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 38 Yrs. 578-76-0085 Virginia Director Usual Residence of Decedent -unk 10c. City, Town or Location 10d. Inside City Limits 10a. State unk 10b. County 28e-f show event, the Medical Examiner roust be notified at unk¹ XYes 2 □ No Director Capital Heights Prince Georges unk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ USA 20743 238 5023 EMO St, unk Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ճ Yes 2 □ No If Yes, Give unknown Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: white à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Importent: If liem 27 is marked other than any injury or other traumatic avantations. car wash person automotive -unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) Marie Fernande Mercier Robert Bernard Duncan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kil Kenny Dr. A Sheville, NC28806 University Specialty Hospital James Duncan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ Removal from State

1 □ Donation 5 □ Crematory or other

1 □ Donation 5 □ Crematory or other 3/7/04 Waldorf, Maryland Robert E. Evans Funeral Stephen Annapolis Road Bowie, MD 20715 21. Signature of Funeral Service Licensee any ir none Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds, cheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Head of mont **Physician** with complication injury EXAMINE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2□No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After Injury 5 Pending investigation s after de-rel Director. Att 1 Natural Deceaned Cell down Stairs 1 ☐ Yes 2 X No 03 UNK 2 Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Capitol Heights, MD filled in by 4 Homicide Home 5023 Street, EMO To the Hospitel or within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mentario 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LHARLI NETTA MD 60/South charlest, Baltimore, MD 21230 CHARU MEHTA MI) 31. Date filed (Month, Day, Year) MAR 0 8 2004 @32. Registrar's Signature

Registrar

June 12

State of Maryland / Department of Health and Mental Hygiene 2 () () ( 06919 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month March 2004r **Physician** Audrey Louise Edgett 11:00 pM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Carroll Lutheran Village Westminster If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Ye June 22, 9. Birthplace (State or Foreign Country)
Connecticut 5. Social Security Number 6. Sex **Funeral** 045-14-9582 1 □ M 2 🛣 F 79 Director Usual Residence of Decedent 10d. Inside City Limits with the Marylend 10c. City. Town or Location 10a, State 10b. County r then "naturel", or items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Glyndon Baltimore Funeral Director Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21071 17 Bellview Ave. death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑No
If Yes, Give
Year or Dates: or Items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 💢 Marned 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: White à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Hospital Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill timent of Heelth and Mental H tent: If Item 27 is marked ott jury or other traumatic even Be Sadie Broadbent Clarence F. Herrmann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 663 Lake Drive, Westminster, Md. 21158 Eugene A. Edgett III - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial ZCremation 3 Removal from State permit. Page Department of importent: If any injury or once. Metro Crematory March 10, 2004 Baltimore, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenser Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117 e 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death chronic obstructive prim. Immediate Cause (Final disease or condition resulting in death) clison Advanced (0 M~> Physician /Medical Due to (or as a consequence of): **Examiner** gestire Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): as the burial Box 68760. Physician/Medical the attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ OAT 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No 1 Yes Vital To the Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Cther: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA Certification: To 2 ER/Outpatient of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending 2 🗆 No death. 1 Yes investigation 2 Accident the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 Homicide pelli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier KE WW 51705 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

N. PANSWRIVA 349 WWW DR , MD 21157 Westminster 3496 M. PANSURIVA morron 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** 4:35 A M Donald Fusco March 1 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 707 Petersburg Road <u>Anne Arundel</u> 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Yrs 76 577-32-7383 02-10-1928 Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Davidsonville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 707 Petersburg Road 21035 USA or items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Depurtment of Health and Mental Hygiene. Important: If liem 27 is marked other than "naturel", or fler any injury or other traumatic event. AMed Folloss: 1 XYes 2 □ No If Yes, Give Year or Dates: W.W. II 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Safety Firefighter 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph P. Fusco Mildred Ann Burleigh ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ramona J. Fusco/ Wife 707 Petersburg Rd., Davidsonville, MD 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 3-4-04 Suitland, MD ¹ 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home white 2973 Solomons Island Rd. Edgewater, Md. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a con equ For insufficience Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): O. Box 68760. Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy ō Day 5 Other (specify) 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 NResidence 6 Other (Specify) 1 Yes 2 No ဥ 27. Manner of Death
1 Natural
2 ☐ Accident 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. î, 29d. Date signed (Month, Day, Year) 29c. License number 03101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMBR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - State of Maryland / Department of Health and Men Certificate of Death	ntal Hygier Reg. 1	- 7111	4 06921
	Physici	217	1. December 1 and		Day Year	3. Time of Death
1	/Medic	al	CHARLES ECKLEY GWYNN, JR.	EBRUARY	27, 200 4c. County of Deal	
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  2303 W. NORTH AVE  BALTIMORE CITY		N/A	
	Funeral		The state of the s	Date of Birth	9. Biri	thplace (State or Foreign
An.	Director		212 26 8051 XM 2 F 75 Yrs. Months Days Hours Min. JU	Month, Day, Yea	1929 M	IARYLAND
	pug *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryli f sho	ō	PATTIMODE			1 XYes 2 □ No
	28a-	Director	10e. Street and Number 10f. Zip Code	10g. (	Citizen of What Co	ountry?
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2-0036	72 hours after death with the Maryland natural; or terma 23a or 28a-f show Jical Exacilizer must be notified at	by Funeral	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Yes or No- in, etc.)	14. Race - Ame Black, Whit Specify:	erican Indian, LÄCK
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lan	be de la be	To B	P CHARLES ECKLEY GWYNN.SR. (DECEASED)   ELEANOR T	. SOLO	MON (D	ECEASED
Maryland	S D E E	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Ro	oute Number, City	y or Town, State, I	Zip Code)
	1 and 2 Health a lem 27 la		PATRICIA M. GWYNN (DAUGHTER) 3034 CLARKSON DR	ABII		MARYLAND
Baltimore,	Pegenent of ant: If any or		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State GARRISON FOREST VET. CEM 4 □ Donation 5 □ Other (Special Special Spec	·		Town, State LLS, MARYLA
Balt	permit. Peg Department Importent: I any injury o		21. Signature of Fundal Service License 22. Name and Address of Facility LEWIS T. GWYNN FULL AND ADDRESS OF FACILITY LEWIS T. GWYNN FULL AND ADDRESS OF FA	NERAL I	HOME 2	1215-6393
г			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.	spiratory arrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		Due to (or as a consequence of):			
	4	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
o,	an an	Exa	Due to (or as a consequence of):			
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9	entifica ling pl	Med	IF FEMALE:			
O. Box	The law requires that the death certifics ate has been signed by the attending ply page 2 should be detached for use as I	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1		23d. Date of dei Month	Day Year
P.O.	res that igned by be deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
rds	w requires been sign should be			1 🗌 Yes	2 No 3 P	robably 4 Dunknown
Records,	aician: The law requiscentificate has been irector, page 2 shoul	Completed		24a. Was an autopsy performed 1 Yes 2 1	prior to death?	utopsy findings available completion of cause of
ta	yaician: is certifica director, p	BeC				
of Vital	<u>&gt;</u> ≥ 0	2	2 1  Yes 2  No  Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA  Other: 4  Nursing Home			cify) SCFINE
n o	ding P n. After t funera	i.i	27. Varier of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Natural 5 Pending (Month, Day Year) Injury 28b. Time of 28c. Injury at 28d.	. Describe how in	jury occurred	
Sio	Attending or death.	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f.	Location (Street	and Number or R	ural Route Number,
Division	or Attendated after death Director:	Certification:	determined determined building, etc. (Specify)	City or Town, St.		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C		due to the cause at the time, date a	(s) and manner as	s stated. e to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier 29c. License number	29d. f	Date signed (Mont	th, Day, Year)
		1	Mayor Doublail HD OCME	I	EBRUARY	28, 2004
	1X		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
	)		YAMPRITA A KORAL 111 Penn Street,	Baltimo	ore, Mary	yland 21201
8	Sta Regist	ate rar	there are a constant and the second			

			For State Registrar	State of Marylan		artment of H rtificate of L		Mental Hy	giene Reg. No.		06922
	Physici /Medic	an	1. Decedent's Name (First, Middle, Last FREDRICK CHARLI		Jr.			2. Date of De Month MARCH	Day	Yeer	3. Time of Death 9:05 a <sup>M</sup>
>	Examin	er	4a. Fecility Name (If not institution, give Lorien Nursing I			4b. City, Town, or Baltim		ath	4c.	County of Deeth	
	Funeral Director		Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)		If Under 24 Hi Hours Min	n. (Month, Da			plece (State or Foreign intry)
	D		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the M s or 28a-f be notifie	Directo	M.D. N/A  10e. Street and Number		altimo	10f. Zip Code	24			izen of What Cou	intry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Marical Examinat must be mailfied at	by Funeral Director	201 N. Washingt  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1  Yes 2 XNo If Yes, Give Year or Dates:		212 Was Decedent of Hill If Yes, specify Cubar 1□ Yes 2☑ No		(Specify Yes or No erto Rican, etc.)		U.S.A.  14. Race - Ameri Black, White  Specify: B1	, etc.
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and 21	2 should be filed within and Mental Hygiene. ie marked other then aumatic event, the M	To Be Cor	7th  17. Father's Name (First, Middle, Last)  Fredrick Charle	es Green, S		cuck Dri		ame (First, Middle	, Maiden		er Compan
Maryland	d 2 shoul h and Me 7 ie mark traumati		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ng Address (Street a					
Baltimore, I	0 = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 1 ☐ Donetion 5 ☐ Other (Specify,	20b. Removal from State	Place of Disponentery, cre	1 Whitwo position (Name of matory or other place n Cemete	9)	Date / 9/2004	20c. Lo	ocation - City or T	own, State
Balti	permit. Pa Departmen Important: eny injury		21. Signature of Funeral Service Licens	800 Nutte	2 2 2	2. Name and Addres	s of Facility N	utter F	une:	ral Hor	me Inc. .D. 21216
	Physician /Medical Examiner	-	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. METASTA  Due to (or as a consect.)  Due to (or as a consect.)	TI C juence of):	LUNG			errest,		Approximate Interval Between Onset and Death
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	sign d be	by	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	inderlying cause give	en in Part I.		tobacco u Yes 2[		the cause of death?
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vision	Attending or death. ector: After by the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, st	M 1 🗆 Y	res 2 □ No	28f. Location (			ral Route Number,
ā	To the Hospital or Attendinition 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Cert	29a. Certifier 1 Cartifying Phy	ysician: To the best of my known	owledge, dear			ce, and due to the	cause(s)	) and manner as	
	To the within 2 To the complete	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number 584 5	7	29d. Dat	te signed (Month,	, Day, Year) 2004
	2		30. Name and address of person who of \$21 N - EVTAW	STREET, BI	n 23a) (Type	Print)			G	EAS AN	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature						

Registrar DHMH 17 Rev 1/2001

ORIGINAL

		•	- For Amend Items 25,2 Registrar		of Marylar	76870481 Ce	artme rtifica	nt of He	alth and l eath			2001	
	Physicia	an	Decedent's Name (First, Middle, Las							2. Date of De Month	Day	Year	3. Time of Death
	/Medic			RDNER			45 0	Y Town or La	ocation of Deat			26,20( County of Dea	045:35 a M
	Examin		4a. Facility Name (If not institution, give Morningside Hou		imber)			-	t Cit			oward	ui
	Europol		Social Security Number 6. S		7. Age (In yrs.	last birthday)	If Und	er 1 Year	f Under 24 Hrs	8. Date of Birt			thplece (State or Foreign
	Funeral Director	- 1		_M 2 <b>∏</b> F	9	3 Yrs.	Month	s Days	Hours Min.	Nov. 18	y, rear)	10 Vi	ginia
	D .		Usual Residence of Decedent  10a, State 10b, County		100 Ci	ty. Town or Lo	ocation				-		10d. Inside City Limits
	ehov	2		_									M☐Yes 2☐No
	28a-f	Director	M . D . M	<u> </u>	8a	ltimo		Zip Code			10a. Citiz	zen of What Co	ountry?
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	72 hours after death with the Maryland natural; or Itema 23a or 28a-f ehow orgal Examiner must be incitified at	Funeral	11. Marital Status		cedent Ever in U	J.S. 13.	Was Dec	cedent of Hisp	anic Origin? (S Mexican, Puer	Specify Yes or No	- 1	4. Race - Ame Black, Whit	
0	or Its		1 Never Married 2 Married		2 3No			_	Specify:	to rilouri, oto.,		SpecifyB1a	
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ary	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene and Mental Hygiene is marked other than "natural", or freme 23a or 28a-f show sumatic event, the Madical Examinat must be intiffied at		19a. Informant's Name/Relationship (7				-			ural Route Numb			
2	ロモトラ		Ellen D. Howard	- NI		Place of Dispo			ite La	ne Colu		cation - City or	
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mental Hygiene. I important: if them 23 a or 28a-f ehov eny injury or other traumatic event, the Madical Examinar must be notified at once.		20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation 3 ☐	Removal from		cemetery, cre.	matory o	rother place)	-k 3/3			timore	
Банты	t. Pa ntmen rtant: njury		*4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen		231								*
a a	Depermine Deperm		21. Signature of Pulmeral Service Licent	1	to								ome Inc. 1.D. 21216
			23a. Pert1. Enter the disease, or comp	lications that	caused the dea							100.,	Approximate Interval Between
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284	death certificate be executed is attending physicien and ed for use as the burial-transit	edicai		d									
XOR	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr		7=				2	3d. Date of de	livery
ň	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 X No		birth 2 Fet gnant at time of		Other	pregnancy (specify)				Month	Day Year
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<u> </u>	icien: The lav certificete has rector, page 2									1 ☐ Yes	2 <b>X</b> No	1 Yes	2 □ No
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ō	Phys rthis raldii	1: 10	1 ☐ Yes 2 X No  27. Manner of Death		Inpatient 2 of Injury	ER/Outpatie		28c. Injury a Work?	4 Ks Nursing i	28d. Describe		Other (Spe	эсну)
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DIVISION	Attendi er death. ector: A by the fu	Hice	3 ☐ Suicide 6 ☐ Could not be determined	289. Plac	ce of Injury - At t ding, etc. (Spec	nome, farm, st	reet, fact	tory, office		28f. Location ( City or To			ural Route Number,
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	thin 2 the I	Med	one)  29b. Signature and title of certifier	and ma	nner stated.			29c. License r	number		29d. Date	s signed (Mon	th, Day <sub>#</sub> Year)
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	La		30. Name and address of person who	completed cal	use of death (Ite	m 23a) (Type	, Print)				-	0-1	)
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	Sta		31. Date filed (Month, Day, Year) MAR 0 8 2004	32.	Registrar's Sign	nature	Low	Ha!					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** P M MARCH 5:00 James Griffin 2004 Ray /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Belair If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1√ M 2□ F 5 1936 North Carolina 67 Director 220 32 3110 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f ehow the Medical Exernings must be notified at 1 Yes 2 No Directo Maryland Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21085 600 Magnolia Avenue USA or Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Mamed 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: 3 Widowed 4 Divorced White natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry jes 1 and 2 should be filled within 72 of Health and Mental Hygiene. If item 27 is marked other then "na prother traumatic event, the Medits College (1-4or 5+) Elementary/Secondary (0-12) Home Improvement Carpenter 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Issac Griffin Molly Baines 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 600 Magnolia Avenue Joppa, Maryland 21085 Alma Arlene Griffin (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō = 5 Important: If eny injury or once permit. Page Department Bayview Crematory Inc 3/6/04 Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, of completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1407 Old Eastern Avenue Essex Maryland 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE POST **Physician** /Medical Due to (or as a consequence of): 3 MONTHS Examiner NON SMALL Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due-to (or as a consequence of) Examiner anding physicien and use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown PULMONTRY CHRONIC ORSTRUCTIVE 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 3 No 24a. Was an has page 2 autopsy performed: After this certificate 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division the Hospital or Attending 1 SNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H55922 MANCH 5, 2004 Do 500 UPPER CHETAPEAKE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMPHILIPO DO BEL AIL 21014 MD 31. Date filed (Month, Day, Year) MAR 0 8 2004 32 Aegistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for Amend Item#23bc, Per ME, 0829, 3/19/Ceg ificate of Death Reg. No. Reg. No. 2004 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 3:24 AM **Physician** GOLDSTEIN 2004 BERNARD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City Under 1 Year If Under 24 Hrs. of Baltimore Sinai Hospital Cit N/A 8 Date of Birth (Month, Day, Year) AUG. 28,1920 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 83 yrs. 9. Birthplace (State or Foreign 5. Social Security Number MARYLAND **Funeral** Months Days Hours 213-12-6246 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State worke | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Items 23e or 28e-1 ehoveny injury or other traumatic event, It is Medical Executive traust be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21209 7202 ROCKLAND HILLS DRIVE #302 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (X) Yes 2 □ No WW I If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. WWII 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CITY OF BALTIMORE **INSPECTOR** 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Siskind Goldstein Be LEVIN GOLDSTEIN MOLLIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9813 MIDDLE MILL DR., OWINGS MILLS, MD 21117 DAVID GOLDSTEIN / SON Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition B'NAI ISRAEL CONG. 1 Burial 2 Cremation 3 Removal from State BALTIMORE, MD 3/5/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial 2 hours Intarction Physician /Medical Due \( (or as a consequence of): Head Injury Examiner 171016 sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of): Examiner TIFICATION APPROVED BY by the attending physician and ached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 Type 2 No. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 donknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ense has e 2 2 1 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death Check on one Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To After thi 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending Motor Vehicle Accident February 28200 4:00 PM 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 ☑No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined Inner Loop Highway

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 695 at exit 2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ew/ RES 000 March 3 2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

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31. Date filed (Month, Day, Year)

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06926 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20040935 PM Dolly Dean Huntemann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Burnis Hrundel Dita ff Under 1 Year | ff Under 24 Hrs. Hrunde 5. Social Security Number A. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. 213-20-9071 Yrs. Director 79 June 11, 1924 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Maryland Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 North Crain Highway 21061 United States Apt. 939 or Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced "naturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) Colfege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Russell Martin Pearl Moore 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun once. Tamara Williams - Daughter 7903A W. B&A Road Severn, Maryland 21144 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 3/10/04 Elkridge, Maryland Gary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ENA /Medical Due to (or as a consequence of): **Examiner** VER CUTE TONITI Sequentially list conditions, if any, leading to influediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed use as the burial-transit F HE and Due to (or as a consequence of): ed by the attending physician detached for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 ☐Ectopic pregnancy Month Year Day 5 Other (specify) P.O. I 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 3 Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 € No 1 ☐ Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Matural To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and till of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

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ed cause of death (Item 23a) (Type, Print)

			1 = For State Registrar	State of Ma	ıryland / [	Department of F Certificate of		ental Hygie Reg	ne 2004	06927
É	Physici /Medic		1. Decedent's Name (First, Middle, La		kck			2. Date of Death Month	Day Year 2004	3. Time of Death
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Maryland	nould be d Mental narked o	10	William R.  19a. Informant's Name/Relationship		ck	. Mailing Address (Street	Thelma	-	Pumphr	
	nd 2 st alth and 27 ls r r traus	1	William R. Heck	(Father		3730 St. Mar			-	
Baltimore,	82 = 5		20a. Method of Disposition 1   Burial 2 □ Cremation 3   4 □ Donation 5 □ Other (Special Control of		cemete	f Disposition (Name of ry, crematory or other place Haven Memori	(e)		c. Location - City or To len Burnie	
Balti	permit. Pa Departmer Importent any injury once.		21. Signature of Funery Service Lice	Town	mle	22. Name and Addre	s desily P01yniak	Funeral	Home P.A. timore, Md	t e
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	To the within To the comp	W	29b. Signature and title of certifier	Mwu		29c. Licens	6211	29d.	Date signed (Month, 3/6/04	Day, Year)
_	, 9			I RWIN,	M. D.	(Type, Print) 300 ( 5.)	Hanover	St. Bal	hmor, me	21275
	Sta Regist		31. Date filed (Month, Day, Year)  MAR 0 8		r's Signature	front :				

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			For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of Hea rtificate of De	alth and Me eath	ental Hygiene Reg. No	2004	06928
	Physici /Medio		1. Decedent's Name (First, Middle, John LeRoy		Jr.			2. Date of Death Month 2 Da Brch 2	<sup>y</sup> 20 <b>0</b> 4	3. Time of Death 2:28 PMM
-	Examir Funeral Director		216-48-8381	re Severna 1	Park e (In yrs. last birthday) 56 Yrs.		ark		ne Arund 9. Birtho Court 1947 Mary	plece (Stete or Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				0d. Inside City Limits
	a-f eh	ctor	Maryland Anne A	rundel	Pasadena					1 □ Yes 2 No
	th with the 23e or 28	Funeral Director	10e. Street and Number 336 Magothy Beau	ch Road		10f. Zip Code	21122	1	tizen of What Cour JSA	ntry?
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or Iteme 23s or 28s-f show or other traumatic event, the Medical Examiner must be motified at	ρ	11. Marital Status  1 Never Married 25 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? d 1 Yes 270 h If Yes, Give Year or Dates:	No I	Was Decedent of Hispa f Yes, specify Cuban, N 1 ☐ Yes 2 No S	anic Origin? (Speci Mexican, Puerto Ri Specity:	fy Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	rithin 72 hound. ne. han "netura	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	(Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of working	16b. K	ind of Business/Ind	
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<u>'lan</u>	should be and Mental marked o	To Be	John LeRoy H	agner Sr.			Lillian	Andersor		
lary	2 should and he la ma		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	ng Address (Street and	Number or Rural F	Route Number, City o	or Town, State, Zip	Code)
	1 and Health em 27 other tr		Carolyn Hagner 20a. Method of Disposition	(Wife)	20b. Place of Dispo	lagothy Pear	ch Road,	Pasadena.	Marylan	d 21122
E O	Pages lent of nt: If it		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		Bayview (	natory or other place)	03/06/0		imore. M	
Baltimore,	permit. Pages 1 an Department of Heal Important; if item 2 eny injury or other 20028.		21. Sign ture of Fune al Service Lie	m00422	22	Name and Address of Cully-Poly Mountai	Facility		0,100	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or constant, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. 6LO	the death. Do not ente	er the mode of dying, su	uch as cardiac or r	espiratory arrest.		Approximate Interval Between Onset and Death 2 16445
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Vital	Physician: r this certifica	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	nt 2 ER/Outpatient	Out.	Place of Death (	Check on one) 5 Residence	COthor (Secret	
Division of	anding Physician: The lath.  or: After this certificate hie funeral director, page	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injur (Month, Day	y 28b. Time of	28c. Injury at Work? M 1 \( \text{Yes} \)	280	Describe how injury		)
Divis	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not determine	building, etc	ury - At home, farm, stre c. (Specify)			. Location (Street and City or Town, State)	)	
	To the Hospitel with n 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination and/or inv	occurred at the time, di estigation, in my opinion	late and place, and in, death occurred	due to the cause(s) at the time, date and	and manner as sta place, and due to	ated. the cause(s)
	To th Vith r To th comp	Ž	29b. Signature and title of certifier	100		29c. License nur	mber	29d. Date	e signed (Month, £	Day, Year)
7	_		1 (m ( c	walle	- w/	1)311	136	MAR	LCH 4	2004
	17		30 me and address of person what a n and a n a	rallace	WD FOCS	Kilbri	ide Rac	id, Nott	nghan I	W) 21236
	Sta Registr			AR 0 8 2004	h's Signature	to Sport	ò		0 (	

Physici /Medi Examir

**Funeral** Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be multiled at once.

Baltimore, Maryland 21215-0036

Owe	ard Jr. 1- State Unper		State of Ja.,27,28a f,F								004	069	29
an	1. Decedent's Nam	e (First, Middle, L	ast)						2. Date of Deat		O Xear	3. Time of Dea 0000A	th
an :al			gene How	<u>-</u>	•		1	(5. 1)	March	· T · · · · · · · · · · · · · · · · · ·			М
er	The state of the s	ngler Wa <u>r</u>	ive street and numb Y	<del>o</del> r)		}	m, or Location imore			4c. Count	y of Death		
	5. Social Security N 214-98-49	983	Sex 7. 1 M 2 □ F	Age (In yrs. lasi	t birthday) Yrs.	If Under 1 \ Months D	ear If Under lays Hours	er 24 Hrs. Min.	8. Date of Birth (Month, Day) May 7, 1	9 8 1	Cou	place (State or Foi ntry) Maryland	
	Usual Residence of 10a. State	10b. County		10c. City, 1	Town or Lo	ocation						10d. Inside City Li	mits
tor	Maryland	N/A	4			Bal	timore					1∭Yes 2[	] No
Olrec	10e. Street and Nu	mber				10f. Zip Co	ode		1	0g. Citizen of	What Cou	intry?	
al	1018 Arm	istead W					21205				u.s.		
nue	11. Marital Status		12. Was Decede Armed Force 1 ☐ Yes 2.	ent Ever in U.S.	13.	Was Deceden If Yes, specify	t of Hispanic ( Cuban, Mexic	Origin? (Spe an, Puerto	ecify Yes or No- Rican, etc.)		ce - Ameri ack, White	can Indian, , etc.	
Completed by Funeral Director	1     Never Marr    Widowed	ried 2 Married 4 Divorced	1 ☐ Yes 2. If Yes, Give Year or Date			1⊡Yes 2X	No <i>Specit</i>	fy:		Speci	ty: Wh	iite	
etec	(Spec	15. Decedent's cify only highest g	Education trade completed)		(Give	dent's Usual C kind of work	lone durina mi	ost of work		16b. Kind of E	Business/Ir	ndustry	
Id III	Elementary/Seco		College (1-4	or 5+)	Ш <b>е</b> .	Depen				A.	/A		
ပိ	9th Grac		st)			vepen		her's Name	e (First, Middle, I		/		
To Be		n E. How						A	Ludrey L	ee			
1	19a, Informant's N				19b. Maili	ng Address (S	treet and Num		al Route Number		, State, Zi	o Code)	
	Audrey B	resnick	(Mother)		1018	Armis.	tead wa	ии. Ва	ultimore	. Maru	land	21205	
			☐Removal from Sta	ate cem	etery, crei	osition (Name matory or othe A Cemen	r place)		004 A	20c. Location			
	21. Signature of Fo	Gneraf Service Lic	ensee						rimunek Utimore				
1	23a. Part1. Enter t shock, or hea	the disease, or co art failure List on	mplications that cau ly one cause on eac	sed the death. h line.	Do not ent	ter the mode o	f dying, such a	as cardiac o	or respiratory arr	est,		Approximate Interval Between	
	Immediate Cause disease or condition	on	Methado	ne Intoxi	icatio	n						Onset and Deat	1
	resulting in death)	-	Due to (or	as a consequer	nce of):								
er	Sequentially list co	mmediate	b. Due to (or	as a consequer	nce of):								
Examine	cause. Enter Unde Cause (Disease or that initiated event	r injury is	c.										
	resulting in death)	Last	Due to (or	as a consequer	nce of):								
edic			0.										
by Physiclan/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months? □No		n 2 ☐ Fetaf de it at time of deat	ath 3[	⊒Ectopic pregi ⊒ Other (speci					ate of deliv	ery Day Year	
by Ph			contributing to deal	th but not resulting	ng in the u	nderlying caus	se given in Par	t I.				he cause of death	
ted									1 _ Ye	es 2□No	3 ☐ Pro	bably 4 □Unkn	own
Completed									24a. Was a autops perform 1 Yes	sy	Were auto prior to co death?	opsy findings avail empletion of cause 2 \(\text{\text{No}}\)	able of
a	25. Was case refe	rred to medical					26. Pla	ce of Death	(Check only on		7	. E 51	
To B	examiner?	] No	Hospital: 1 □ Inp	atient 2 EF	VOutpatier	nt 3 DOA	Other: 4 🗆 I	Nursing Ho	me 5 ☐ Reside	ence 6 ⊠Ot	her (Speci	(scene	)
	27. Manner of Dea 1 □Natural	th 5 Pending		Injury 28 Day Year)	Bb. Time o		Injury at Work?	_	28d. Describe ho	ow infury occu	rred		
Certification:	2 ☐ Accident	investigat	be	Makin All	unkno		1 ☐ Yes 2		unknown		h	al Davids Att	
irtifi	4 ☐ Homicide	determine	ed 288. Flace of building	Injury - At home , etc. <i>(Specify)</i>	e, rarm, sti	reet, factory, o	пісе		City or Town	n, State)		al Route Number,	
ပ္ပ			home					9	913 Spang1	er Way,	Baltin	nore MD	

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

> 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signate

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) March 02, 2004

m 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medical Ce

29a. Certifier

MAR 0 8 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For State Registrar	State of Marylan	d / Depa <i>Cer</i>	artment of H tificate of L	ealth and M Death	lental Hygie	2004	06930	
	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month	Day Year	3. Time of Death	
	Physicia Medic/		MARY S. HATTER					MARCH 4	4, 2004	7:15 A. <sup>M</sup>	
	Examin		4a. Fecility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of Death		4c. County of Dea		
			OAK CREST VILLAGE			PARKVIL	LE If Under 24 Hrs.	O Data of Birth	BALTIM		
	uneral		5. Social Security Number 6. Sex	7. Age (In yrs.	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Bir	thplace (State or Foreign buntry)	
D	irector		219-03-0270 Usual Residence of Decedent	** 89				7/22/19	14 INE	W JERSEY	
land	ral, or items 23a Examiner must	tor	10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits	
Мал			MD BALTIMOR	<b>E</b>	PAR	KVILLE				1 ☐ Yes 2 ☐ No	
h the		Director	10e. Street and Number			10f. Zip Code		. Citizen of What Co	ountry?		
th wit		ai	8830 WALTHER BLVD.	APT. 119		212	34		USA		
r dea		Funeral	11. Marital Status	. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi		
afte		by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 📉 No	Specify:		Specify: W	HITE	
d 6 16 10 0000			3 ☐Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation					16	b. Kind of Business		
n 72		Completed	(Specify only highest grade of	completed)	(Give	kind of work done of DO NOT use retired	during most of work			,	
with	the M	E O	Elementary/Secondary (0-12)  12TH GRADE	College (1-4or 5+)	SAL	ESPERSON			DEPT. ST	ORE	
D	I Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Madical	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Ma	iden Sumame)		
should be		0	WALTER STANKIWICZ				MARY HE	ELEN UNAL	ATLABLE		
2 shot		_	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailir	ng Address (Street a	and Number or Run	al Route Number, C	city or Town, State,	Zip Code)	
and 2	127 E		CHRISTINE L. GRANER	NIECE		COVERED			MORE, MD	21234	
98 -	of He I Item r oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rea	1 /	Place of Dispo cometery, crem	sition (Name of matory or other plac	(6)		c. Location - City or	Town, State	
Pages	Department of Hea Important: If Item any injury or othe once.		*4 □ Donation 5 □ Other (Specify)	ME		EMATORY,		5/2004 C	ATONSVILL	E, MD	
permit. Pages	Depart Import any inj once.		21. Signature of Euneral Service Licensee		22	2. Name and Addres	ss of Facility THE	E JOHNSON		HOME, P.A.	
2	0 = = a	/	1/1					D. TOWS		1286 Approximate	
			22a. Part. Enter the disease, or complications shock, or heart failure. List only one	cause on each line.	$\sim$	1		or respiratory arrest	,	Interval Between Onset and Death	
	ysician		Immediate Cause (Final disease or condition resulting in death)	ASCV		no take	/			Month	
	ledical aminer		Due to (or as a consequence of):								
E.	physician and the burial-transit	ē	Sequentially list conditions, frank, leading to immediate bus to (or as a consequence of).								
uted		Examiner	of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
The law requires that the death certificate be executed		Exa	resulting in death) Last Due to (or as a consequence of):								
9 9 9		cal	d								
diffica	as a	Physician/Medi	IE EEMALE.								
S E	ed by the attending ph detached for use as th	an/h	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy					23d. Date of delivery Month Day		
o dea		sici	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 □ Pregnant at time of death 5 □ Other (specify)					Month Day Year		
lat the	d by t etach	Phy	9 Unknown	sibuting to dooth but not rec	ulting in the u	ndorhing cause and	on in Part I	23a Did tohar	co use contribute t	o the cause of death?	
res th	within 24 hours after death.  To the Funeral Director: After this certificate has been signed E completely filled in by the funeral director, page 2 should be detended.	b	and the original control of the cont						Yes 2 No 3 Probably 4 Oknown		
Ords,		Completed						-			
a a v		npje						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of	
# #								1□ Yes 2月	No 1 □ Ye	2 2 16	
OI VIII		Be	25. Was case referred to medical examiner?	spital:	IED/O	Oth		h (Check only one)	0 Dotter (0-		
2 £		. To	1 Yes 2 No	28a. Date of Injury	28b. Time o			ome 5 Residence 28d. Describe how		ecity)	
ding and		Ė	1 ☐ Natural 5 ☐ Pending (Month, Day Year 2 ☐ Accident investigation								
Atten		fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s			reet, factory, office		28f. Location (Street	i. Location (Street and Number or Rural Route Number, City or Town, State)		
5 0		Certification:	4 ☐ Homicide building, etc. (Specify)					City of Town,	n, state)		
pspit											
he Hc	in 24 the Fi	ledical	one)	and manner stated.	and and or m						
Tot	To 1	Σ						I. Date signed (Month, Day, Year)			
			1 (1111)				3115		3/4/04		
	19		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  To FF Conditions MO REDO WOLTHW BILD PARTIE ITO 21234								
			Jeff (marma 31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	ua ithm	DIVO	LINENIC	11000	- 3 -1	
	Sta	ate	MAD 0 0 2	- 64	20	A . St 0	44				

3/4/04 mary Hatter 7'am

		4	For State	State of Maryla	•	tment of Healificate of De			2006	06931	
			Registrar  1. Decedent's Name (First, Middle, La.	st)	Octi	neate of De		Reg. 2. Date of Death	No. 62 0 0 9	3. Time of Death	
	Physicia		Sarah :	IMAN			1	WARCH (	3 200A	0315AM	
X	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		b. City, Town, or Lo	cation of Death	6	4c. County of Death		
1			303 hONG		VE.	0-11-1	BURNU	-	H.A.C	· O ·	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs			Hours Min.	B. Date of Birth (Month, Day, Ye MAXCIT LO	ar) . Cou	place (State or Foreign	
10.0	Director	-	236 - 68 - 2535 Usual Residence of Decedent		/		/	MACHINE	11/19 W	, VA .	
	yland		10a. State 10b. County		City, Town or Loca				1	0d. Inside City Limits  12 Yes 2 □ No	
	e Mar	ct o	MD. A.A	.Co	SLAND	BURNIE					
	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. In marked other than "natural", or iteme 23a or 28a-f show umartic event, the Medical Examinar must be notified at	Director	10e. Street and Number	WADD AUE		10f. Zip Code	261	10g.	Citizen of What Cour	ntry?	
id 21215-0036		erai	363 LONGO	12. Was Decedent Ever in		is Decedent of Hispa		ify Yes or No-	14. Race - Americ	can Indian,	
		Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 2 No	If Y	es, specify Cuban, I	Mexican, Puerto R	ican, etc.)	Black, White,	etc.	
		d by	3 ∰Widowed 4 □ Divorced	If Yes, Give Year or Dates:		Yes 2 No 5	Specify:		Specify:	HITE	
		Completed	15. Decedent's E (Specify only highest gra		(Give kii	nt's Usual Occupation and of work done duri ONOT use retired)	on ing most of working	7	o. Kind of Business/In	dustry	
		ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		SEKEE	DER	6	BRANT /	4037	
		BeC	17. Father's Name (First, Middle, Last			18	Mother's Name	First, Middle, Mai	den Sumame)		
Maryland		To	AROLD VAL	SMETER		1		MAE MI		21.61	
Jar	2 sho		19a. Informant's Name/Relationship (	Type, Print) HIEF	303 L	Address (Street and	DD AVE		ity or Town, State, Zip		
-	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 le marke eny injury or other traumatic 8006.	1	20a. Method of Disposition	206.	Place of Disposit	ion (Name of	/ /		c. Location - City or To		
nor			1 Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Special		cemetery, crema HFMAHS I	tory or other place)	MARC	04 1	ATMENS	VILLEWILL	
Baltimore			21. Signature of Euneral Service Mce			Name and Address	of Facility 2	829 HL	1050 N Si		
Ö	Depa Impo eny i		I homas	Akardo	X . 0)	KARDA /.	14 - 3	ALF TTO.	MA 21.	274	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only	iplications that caused the decore cause on each line.	ath. Do not enter	the mode of dying, s	such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death	
			Immediate Cause (Final disease or condition resulting in death)	a.	ENTIA	4				5YEARS	
			1	Due to (or as a conse	equence of):					5 YOURS	
19		Je .	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a const	or as a consequence of):					076710	
		Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events  c								
90,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conse	equence of);						
8760	cate be ex physician the buria	dicai		_ d							
9 x	leath certifica attending ph ifor use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		100000			23d. Date of deliv	ery	
Box.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	iciar	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		ctopic pregnancy Other (specify)			Month	Day Year	
P.0		hys	9 Unknown		an a second						
		Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  RHEMATOLD ARTHRITIS				in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown			
oro		eted	•	e HEART		1100					
Rec		mpi	CONGOSTIV	e verici	1-14/ [	U re		24a. Was an autopsy performed	prior to co death?	opsy findings available impletion of cause of	
tal		a)	25. Was case referred to medical			2	6. Place of Death	(Check only one)	No 1 ☐ Yes	2 LJ No	
>		To B	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3 DOA Other			e 6 Other (Specia	(y)	
0 0		:uo	27. Manny of Death 1 Satural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		8d. Describe how	f. Describe how injury occurred		
Sio		cati	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 28e Place of Injury - At home farm street factory office. 28f Location /Street and Niu						at and Number or Rus	al Route Number	
Division of Vital Records,		Certification:	4 Homicide determined				<ol> <li>Location (Street and Number or Rural Route Number, City or Town, State)</li> </ol>				
	spital nours naral filled										
	he Ho in 24 I he Fu pleteb	edical	one)	and manner stated.	ination and/or inve						
	To t To t	Σ	29b. Signature and title of certifier	144	unmi	29c. License n	6266	3 11/	Date signed (Month,	2004	
	. ^	1		a completed	lom 22-1 /	rint)	636C	100	Mach 3	2007	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  No. CHARL  4. AND PRINT BAYYON CIPCLE  31. Date filed (Month, Day, Year)  32. Registrar's Signature								
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	BALT	Inope,	MOZ	224		
11.	Regist		MAR 0 8	2004 Blacera	1 15 6	partie					

Flora Jones 04-01685 MAN

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ŋ			1 - For Unpend Iter: #23a	State of N	Marylan per ne G	d / Dep 330 27 f	artment	of H	ealth a	and M	lental Hyg	giene 1. No. 2	004	06933
			Decedent's Name (First, Middle, La.								2. Date of Dea	th		3. Time of Death
	Physic /Medi		FLORA J. JONES	3							Month March 0	7, 2004	Year	0128 A M
j	Exami		4a. Fecility Name (If not institution, give	street and number	er)		4b. City,	Town, or	Location	of Death			nty of Death	
			332 Federal Street				Ba	ltim	ore				NA	
P	Funeral		Social Security Number     6. S	ex 7 1∑M 2 ☐ F	Age (In yrs. I		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	nplace (State or Foreign
4	Director		227-66-3625	Miw 571	5	8 Yrs.					JUN 28, 1			VA
	yland		Usuel Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Marylan febow	Director	MD NA				T) A T (T) T	34000						1 X Yes 2 □ No
	the Man r 28e-f eh		10e. Street and Number				BALTI 10f. Zip			-		l0g. Citizen	of What Cou	intar?
	death with the Maryland me 23a or 28e-f ehow		332 E. FEDERAL STRI	četr					21202					
		Funerai	11. Marital Status	12. Was Deceder	nt Ever in U.	S. 13.	Was Deced			igin? (Spe	ecify Yes or No- Rican, etc.)	14. F	USA Race - Amer	ican Indian,
9	after or ite		1 ☐ Never Married 2 X Married	Armed Force 1 ☐ Yes 2) If Yes, Give			tYes,spec 1 □ Yes 2	37			Rican, etc.)		Black, White AFT	i, etc. RICAN
5-0036	72 hours after naturel; or ite	d by	3 Widowed 4 Divorced	Year or Dates	s:		1 195 2	KE NO	Specify:			Spe	city:	MERTCAN
5	natur	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	ient's Usua kind of wor	k done d	urina mos	t of worki	ing	16b. Kind of		The second secon
2121	d withir giene. or then	m d	Elementary/Secondary (0-12) 9th	College (1-40	or 5+)	irte. I	DO NOT us	,						
d 2	e filed withing the Hygiene. other then		17. Father's Name (First, Middle, Last)	0			HOUS	EWIFE		ar's Namo	(First, Middle,	Maidan Sum	HOME	S
Maryland	d be ental	o Be	WADE FOWLKES	•					TO. WIOLITE			MaiDeri Surii	aurie)	
2	permit. Peges 1 and 2 should be filed Department of Health and Menlal Hyg Important: If Item 27 is marked othe eny injury or other treumatic event, ODGs.	ို	19a. Informant's Name/Relationship (			19b. Mailin	n Address	(Street a	nd Numbe		NIGHT  NUMBER	City or Tou	en Stato 7	in Code)
			CHARLEEN G. WYLIE (DA	UGHTER)			SILSTON				NSVILLE,			p Code)
ē,			20a. Method of Disposition			lace of Dispo	sition (Nam	e of	1			20c. Locatio		own, Stete
Ë			1 🖾 Burial 2 □ Cremation 3 □  14 □ Donation 5 □ Other (Specify		(e	emetery, cren ZION CE		ner piace	1	/12/0	<i>,</i>	T ANICT	DOE 78.777	140
altimore,			21. Signature of Funeral Service Licen		1111		. Name and	d Addres		H 35-FF			DOWNE,	MD
m				Men		1 6	38 M	CTLMO	ומידים מ		E FUNERAL		A 217	
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ξ	Physicien: this certificant ral director,	Be	25. Was case referred to medical examiner?	Hospital:			_	Othe			(Check only on			
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	To the Hospitet or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medicai	one)	iner. On the basis and manner	or examinati	ion and/or inv	estigation, i	in my opi	nion, deat	th occurre	ed at the time, da	ate and place	e, and due t	o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	ol.			29c.	License	number		2:	9d. Date sign	ned (Month,	Day, Year)
			Malgine A	nel frell	- MP		(	O.C.	M.E.			March	o 07,	2004
_			30. Name and address of person who of MANGAMTA	completed cause of	death (Item			enn :	Stree	et. P	altimor	o Mar	സിച്ച	1 21201
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	ROCHIE JONES						,																							
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	20a. Method of Disposition	20b. Plac	e of Dispos	GLSION P sition (Name of natory or other pla	ARK ROBO - (	Date 2	Mi) 21223 Oc. Location - City or To	own, State																						
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E	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home	- INCLUDE TITE		Il Route Number,																									
Cer	4 - Homeod	Residence				Baltimore (	Siate/332 redera City, Md	11 Street																						
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¥ -	29b. Signature and title of certifier			29c. Licens	se number	290	I. Date signed (Month,	Day, Year)																						
	Maria	no (theld i)	W	0.0	.M.E.		March 07.	2004																						
-	30. Name and address of person who co	ompleted cause of death (Item 2)	3a) (Tyna F																											
	IYARYARTA A.	KOREU	Ja, (1996, 1	,																										
Certification: To Be Completed by Physician/Medical	Columbiation, 10 be completed by rugalcial medical	23a. Part I. Enter the disease, or come shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	298. Part1. Enter the disease, or constitutions that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to mimodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 230. Was decedent pregnant in the past 12 months? 1   Yes 2   No	23. Signature of Funeral Service Licensee  23. Part I. Enter the disease, or constitutions that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  3. Sinoke and Soot Inhalati  Due to (or as a consequence of):  3. Due to (or as a consequence of):  4. Due to (or as a consequence of):  5. Due to (or as a consequence of):  6. Due to (or as a consequence of):  7. Due to (or as a consequence of):  8. Due to (or as a consequence of):  9. Due to (or as a consequence of):  9. Due to (or as a consequence of):  1. Due to (or as a consequence of):  1. Due to (or as a consequence of):  1. Due to (or as a consequence of):  1. Due to (or as a consequence of):  2. Due to (or as a consequence	22. Name and Addre  638 N. GTI  236 Part1. Enter the disease, or commetations that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, leading to mimediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  24c. If yes, outcome of pregnancy 1 Like birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (specify) 9 Unknown  25c. Was case referred to medical examiner?  27c. Was case referred to medical examiner?  27c. Was case referred to medical examiner?  27c. Manner of Death 1 Notural 1 Notural 1 Notural 1 Notural 1 Notural 2 Notural	21. Signature of Funeral Service Licensee  22. Name and Address of Facility 638 N. GITMOR STREE.  236. Parti. Enter this disease, or compensations that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease) or condition resulting in death)  Sample and Scot Inhalation  Due to (or as a consequence of):  b. Due to (or as a consequence of):  b. Due to (or as a consequence of):  d. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (o	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  WILLE FUNE  638 N. GITMOR STREET RALTIMORE  236. Parti. Enter the disease, or commissions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease) or commission one cause on each line.  Immediate Cause (Final disease) or commission one cause on each line.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that intellated events resulting in death)  23. If yes, outcome of pregnancy 10 we birth 2 = fetal death 10 or their (specify) 11 we birth 2 = fetal death 10 or their (specify) 12 we birth 2 = fetal death 10 or their (specify) 12 we show 10 or the	21. Signature of Fungal Service Leangee  22. Name and Address of Facility  WXLTE FUNDRAL HOVE PA  638 N. GTIMOR STREET RALTIMORE, MD 21217  236 Perff. Enter this disease, or cognifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease) or cognifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease) or cognifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock correctly arrest, and the cause of the complete of the mode of dying, such as cardiac or respiratory arrest, shock correctly arrest, and the cause of the complete of the cause of																						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 06935 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 5:40 AM March Joyce 2004 Dorothy 4ç. County of Death 4a. Facility Name (If npt institution, give street and number) 4b. City, Town, or Location of Death + 105p + tal x 7. Age (In yrs. last birthday) Anne Annall orth Armoel Glen Burnie If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 86 Vrs 220-07-1755 Dec 26, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No Severn Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21144 1218 Somerset Road U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Factory 12 Machinist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Elizabeth White Maurice Hampton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Severn, MD 21144 1218 Somerset Road Mrs. Natalie Melaragno/Neice 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State Mar 6 2004 Louden Park Cemetery Baltimore, MD 4 □Donation 5 □ Other (Specify) 21. Signature of runeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, 1 Second Avenue, S.W. Glen Burnie, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition UROSEPSIS WEEK resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Striknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 ☑ffipatient 2 ☐ ER/Outpatient 3□ DQA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide

1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D46962

HOSPITAL.

29d. Date signed (Month, Day, Year)

03,2004

MARCH

MD 21061.

**Physician** /Medical Examiner certificate be executed the attending physicien and hed for use as the burial-transit

Examiner

Physician/Medical

Completed

Be

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Certification:

Medical

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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**Funeral** 

Director

item 27 is marked other than "natural", or itema 23e or 28e-1 ahow other traumatic event, the Medical Examinar must be notified at

d 2 should be fited within 7, th and Mental Hygiene. 7 is marked other then "na

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any injury or other traumatic event.

Baltimore,

P.O. Box 68760.

Division of Vital Records,

been signed by the should be detached

To the Hospitel or Attending Phys within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral dir

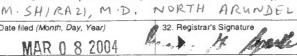
State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 - Homicide

29a, Certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 0 8 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (Fifs), Middle, Last) Month 335D M 2004 29 Hebruan 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Battimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth last birthday 5. Social Security Number 6. Sex/ 100 M 2 ☐ F Months Days Hours Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location unll 10a. State UNC 10b. County UMC 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? Und 10f. Zip Code 10e. Street and Number Lull Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11. Marital Status UUUL 1 ☐ Never Married 2 ☐ Marned ☐Yes 2☐No 1 ☐ Yes 2 No If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry und most of working unce College (1-4or 5+) Elementary/Secondary (0-12) una und 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other) 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3/3/04 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Approximate interval Between Onset and Death emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ne cause on each line nelemoni 0 Due to (or as a consequence of):

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-1 show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23e or 28e-f show sny injury or other traumatic event, the Medical Examination in willied at

Baltimore, Marylahd 21215-003

Be Completed by Funeral Director

burial-t attending physician for use as the buria Physician/N by the a s been signed b Completed by page 2 Be 2 Certification; within 24 hours after death

To the Funeral Director:
completely filled in by the

ģ

has

this certificate

After death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

	shock, or heart failure. List only of
	Immediate Cause (Final disease or condition resulting in death)
n/Medical Examiner	Sequentially list conditions, I any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
n/Mec	IF FEMALE: 23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown

23d. Date of de	elivery	
Month	Day	Year
		23d. Date of delivery Month Day

9 LI OTIKNOWIT	
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.

Due to for as a consequence of

Due to (or as a consequence of):

23e. Did tobacco us	se contribute to the o	ause of death?
1 ☐ Yes 2 ☐	]No 3 ☐ Probabi	y 4 Donknown
24a. Was an autopsy	24b. Were autopsy prior to compl	findings available letion of cause of

1 ☐ Yes 2 ☐ M	1 Yes 2 !
eath Check on one	
Home 5 Residence	6 ☐Other (Specify)

25. Was case referred to medical examiner? 1 □ Yes 2 □ No			26. Place of Death Check on one							
		,	Hospital: 1 Inpatient 2	nt 2 ER/Outpatient		3 DOA Other: 4 Nursing H		Home 5 ☐ Residence 6 ☐ Other (Specify)		
27	Manner of Death  Natural  Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work?		28d. Describe how injury occurred		
3 Suicide 6 Could not be determined		28e. Place of Injury - At home, farm, street, factory, office					28f. Location (Street and Number or Rural Route Number, City or Town, State)			

4 🗆 Homicide		building, etc. (Specify)	Q.i.y c	- · · · · · · · · · · · · · · · · · · ·
29a. Certifier (Check only one)	2 Medical Examiner: On		rred at the time, date and place, and due to the time, date and place, and due to the time, in my opinion, death occurred at the time.	e, date and place, and due to the cause(s)
			20- License number	20d Data signed (Month Day Vear)

(Check only one)  2 Medical Examiner: On the basis of examination and/or investiged and manner stated.	pation, in my opinion, death occurred at the time	e, date and place, and due to the ca
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Ye
	89508	2.29.A11

30. Name and address of person who	completed cause of death (item 23a) (Type Print)

) ( I y	De Print)	^ -
	Co	Ma

ryland General

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		State	
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Medi



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month PM Physician Maren Francis J. Kuhn 2004 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Ballimore GOSEDALE

If Under 1 Year | If Under 24 Hrs. Hospital Center quare 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 1 M 2 □ F 212-44-2192 61 6. Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b County 10a, State r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Baltimore Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 1314 Sleepy Hollow Lane U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Vectnam Year or Dates. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 🕱 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Ore Analyst Consulting permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien. Important: If tem 27 Is marked other the any injury or other traumatic account. 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pancratius Kuhn Hertha Stewart 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Margaret Kuhn (wife) 1314 Sleepy Hollow Lane, Baltimore, MD 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Parkwood Cemetery 3/10/2004 Parkville. Maruland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licens 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Embol TUIMORALY **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infinite diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se si cur eequands of) Examine burial-transit Due to (or as a consequence of) Box 68760. attending physician pe Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No certificate 1 ☐ Yes Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check or one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ar 0056296 person who completed cause of death (Item 23a) (Type, Print) 30. Name and ddress of 9000 Squire brive Baltimore, MD 21237 Or. Joson Birnbaum
31. Date filed (Month, Pay, Year) 32. 31. Date filed (Month, Day, Year) 32. Registar's Signature State 8 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 0 6 9 3 8

Certificate of Death

Reg. No.

2. Date of Death
Month Day Year 3. Time of Death
Month Day Year 3. Time of Death

Physician
/Medical
Examiner

**Funeral** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

The marked other then "natural", or items 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Examination and once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division of Vital Records, P.O. Box 68760

•	1 - For State Registrar	olato of mary	$C\epsilon$	ertificate of	Death	ornar i i	Reg. No.	104	00938
	1. Decedent's Name (First, Middle, Last)	101				2. Date of De	eath Day	Year	3. Time of Death
	James	KOLDE	R			3	2	04	6:33 a.M.
1	4a. Fecility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of Deat	h	4c. Cour	nty of Death	
	Baltimore Kehabili	tation Exten	ed ad Car	e /3 a	11 mas				· · · · · · · · · · · · · · · · · · ·
ì	5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday	Months Days	If Under 24 Hrs Hours Min.	(Month, D	ey, Yeer)	Cou	plece (State or Foreign intry)
	217-30-5234 Usual Residence of Decedent		68 Yrs.			January	4,1936	Mary	Land
}	10a. State 10b. County	100	c. City, Town or L	ocation					10d. Inside City Limits
5	Maryland Baltimo	ro	Wood	Lawn					1 ☐ Yes 2 🖸 Ño
3	10e, Street and Number	1.0	woods	10f. Zip Code			10g. Citizen	of What Cou	ntry?
2	2201 Sunbriar Re	and		21	207		II C	S.A.	
2		12. Was Decedent Ever	in U.S. 13	. Was Decedent of H		Specify Yes or N		ace - Ameri	
3	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 XYes 2 ☐ No				to Rican, etc.)		lack, White,	, etc.
2	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Spec		hite
	15. Decedent's Edu (Specify only highest grade	cation completed)	(Giv	edent's Usual Occup	during most of wo	rking	16b. Kind of	Business/Ir	ndustry
2	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d) -				
5		1+	Commu	inications		/FiA & # # intelle	·	S. Ar	my
מ	17. Father's Name (First, Middle, Last)	1				me (First, Middle			
2	Charles Joseph Ko	<u>-</u>	401 44			Catherin			- Cadal
	19a. Informant's Name/Relationship (Ty			ling Address (Street					
	Patricia Kolper 20a. Method of Disposition	(Wife)		Sunbriar		Date Date	Mary Lan 20c. Locatio		
	1 🖾 Burial 2 🗀 Cremation 3 🗆 R	emoval from State		osition (Name of ematory or other place					
	<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>			1 Cemetery 22. Name and Addre		5-2004	MoodTM	an, M	aryland
	21. Signature of Punetal Service License	<b>D</b> MOO8	V	Vitzke Fur	eral Hom	ne of Ca	tonsvil	le, I	nc. ryland 2122
	23 Part1. Enter the disease, or compli- thock, or he) if failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	Fie C	arcimo				(	Interval Between Onset and Death O M on this
5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):						
70	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):						
5		4							
Calcal		J							
yalolalum	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1□Live birth 2□ 4□Pregnant at time 9□Unknown	Fetal death 3	☐Ectopic pregnancy	/			Date of deliv	ery Day Year
	Part II. Other significant conditions con	ntributing to death but no	t resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to t	the cause of death?
3						1 🗆	Yes 2 No	3 🗌 Pro	bably 4 Unknown
completed							an 24l psy ormed?	o. Were auto prior to co death?	opsy findings available ompletion of cause of
5	25. Was case referred to medical				26 Place of De	1 ☐ Yes ath Check only	2 No	1 🗆 Yes	2 ☐ No
2	examiner?	lospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Ott	or	dome 5 ☐ Res		ther (Speci	tv)
	27. Manper of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye		of 28c. Injur			how injury occ		97
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	28e. Place of Injury - building, etc. (S	At home, farm, s pecify)	street, factory, office		28f. Location ( City or To	(Street and Nui wn, State)	mber or Run	al Route Number,
edical certification		sician: To the best of m ner: On the basis of exa and manner stated.							
DIA	29b. Signature and title of certifier			29c. Licens			29d. Date sign	ned (Month,	Day, Year)
	I c	Carl	m.7	J.	359 (	0 H10)	3 -	2 0	74
	30. Name and address of person who co	impleted cause of death	(Item 23a) (Type	e, Print)					

Registrar

John S. Lah m.D

MAR 0 8 2004

3900 Loch Raven Boulevard, Baltimore, Maryland 21218
32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				(	Certificate of	Death	F	Reg. No. 200	4 06939
	Dhusisian	1. Decedent's Name (First, Middle, La					2. Date of Dee	oth Dey Year	3. Time of Death
No.	Physician /Medical	100	ittle					1-01-200	
1	Examiner	4a Fecility Neme (If not institution, giv.  Long Green – Ger		care		Baltimo		,	th
	Funeral Director	5. Social Security Number 6. S 218–18–9660	ex 7. Age (fi	n yrs. lest birth 88 Y	Months Days		8. Date of Birth (Month, De) March	(Yeer)	thplace (State or Foreign ountry) CGINLA
	pug 🗼	Usuel Residence of Decedent  10e. State 10b. County	10	c. City, Town	or Locetion				10d. Inside City Limits
	Varyle f sho	Maryland	1	Balti					1X Yes 2 □ No
	r 28a	10e. Street end Number		Dares	10f. Zip Code			10g. Citizen of What C	
	th wit	115 East Melrose	Avenue		2	21212		United Sta	
21215-0020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:	r in U,S.	13. Was Decedent of If Yes, specify Cult 1 ☐ Yes 2 No		Specify Yes or No- rto Rican, etc.)		
5-0	72 ho	15. Decedent's Ed (Specify only highest gre		16a. E	Decedent's Usual Occu Give kind of work done life. DO NOT use retire	pation during most of w	orking	16b. Kind of Business	/Industry
121	ed within 72 hours a ygiene. Nor than "natural", c it, the Medical Exar Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		iiie. <i>DO NOT use retire</i> jistered Nu			Steel Comp	)anv
<b>d</b> 2	Hygie Hygie after 1	17. Father's Neme (First, Middle, Last)		1100	JIBCCICA IVO		ame (First, Middle,		All y
lan	should be fill and Mental H marked oth umarke over urmarke even	George Washington	Little			Flora B	ell Ford		
Maryland	2 should be and be is man	19a. Informant's Name/Relationship (	** *					r, City or Town, State,	
	1 end 2 Health em 27 i	Arthur L. Drager	-					Baltimore	·
Baltimore,	. Pages 1 ment of H tent: if iter jury or oth	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	()	cemetery Meadowr	Disposition (Name of , crematory or other place idge Memor	rial Pk.	Date 3/5/04	20c. Location - City or Elkridge,	
Ball	permit. Pag Department Important: I any injury o pnce.	21. Signature of Funeral Service Licer	see			ufman Fu		me At MMP., Elkridge,	
		23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do no					Approximate Interval Between
	Physician	2				^			Onset and Death
1	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a		on dias	L 17	rvest		
	je stalina je		Due	o to (or as e co	onsequence of):				
	cuted nd ransit	Sequentially list conditions,	b	e to (or as e co	onsequence of):				
ő,	e exe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	1	hal	peles :	mellet	ue		1
68760,	rifficete be executed ng physician end e se the buriel-transit	that initiated events resulting in death) Last	Due	to (or as a co	nsequence of):				
X 6	certification of the second of	L L	d						
. Box	The law requires that the death certificate be executed as has been signed by the attending physician end page 2 should be deteched for use as the buriel-transit completed by Physician/Medical Examin	Part II. Other significant conditions o	ontributing to death but n	ot resulting in	the underlying cause g	iven in Part I.	23b. Did t	obacco use contribute	to the cause of death?
P.0	by the steche		A	10	^		101	/es 2□ No 3□ P	robably 4 Dunknown
S,	es the igned be de	Deme	works.	474	benjana	100			
of Vital Records,	The law require sete has been single 2 should Completed	Aneuria					24a. Was a	an autopsy 24b. med?	Were autopsy findings available prior to completion of cause
3ec	has b						4.74	_/	of death?
la		25. Was case referred to medical				26 Place of D	ath (Check only o		1 ☐ Yes 2 ☐ No
5	Physician: The lithis certificate harrel director, page	examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Out	patient 3 DOA	than .		lence 6 □Other (Spe	ocify)
10	₹ ₹	27. Menner of Deeth 1 ☐ Natural 5 ☐ Pending	28e. Date of Injury (Month, Dey Ye					ow injury occurred	,
Sior	Attending or death.  octor: After by the fune	2 ☐ Accident investigation			M 1	Yes 2□No			
Division	or Att efter d Direct I in by	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (5	- At home, fari Specify)	m, street, factory, office	•	28f. Location (S City or Tow	Street and Number or R n, State)	urel Route Number,
	pital ours eral Dilled	29a. Certifier 1 Certifying Ph	ysician: To the best of m	v knowledge	death occurred at the t	ime date and plac	e and due to the o	euse(s) and manner a	s stated
	To the Hospital or Attending Phwithin 24 hours efter death. To the Funeral Director: After thicompletely filled in by the funeral Medical Certification: 7		niner: On the basis of example of menner stated	amination and					
	To the within To the comple	29b. Signature and title of certifier	0		29c. Licer	se number		29d. Date signed (Mon	th, Day, Yeer)
		> Who	She		DO	20539		3-1-01	7
	/	30. Neme end address of person who	completed cause of death					٨٨	
	30-20-	Vijay R. Kegde 31. Date filed (Month, Day, Year)	MB., 82 32(Registrer's	Signeture	utaw St.,	Suite 30'	o, Ba	comone,	MD 21201
	State Registrar	MAR 0 8 201	14 Liber	St.	books				

			For State Registrar	State of Mary	•	artment of				ene . No. 20	04	06940
	Physici	an	Decedent's Name (First, Middle, Last)						Date of Death Month	Day	Year	3. Time of Death
	/Medic	cal	Yun Sook Li			45 City Town	and applied to		rch		2004	9:50 A M
	Examir	ner	4a. Facility Name (If not institution, give st 907 Highstepper Tra			4b. City, Town	esville			4c. County		
-	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Yea	ar If Under	24 Hrs.   8 F	ate of Birth		9. Birthp	lace (State or Foreign
	Director		215-66-2424	M 2XF	69 Yrs.	Months Day	rs Hours		Month, Day, Y	1934	Coun Kore	
	pu .		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	ecation					11	0d. Inside City Limits
	Maryla f sho	ō										1 ☐ Yes 2 ☑ No
	28e-	rect	Maryland Carroll  10e. Street and Number		Sykesv	10f. Zip Code	9		10g	. Citizen of V	Vhat Coun	try?
	death with the Maryland ms 23s or 28e-f show r nust be nutilized at	aiD	907 Highstepper Tra	ail		21	784			United	l Stat	tes
	2 hours after death with the Marylan atural', or Items 23a or 28e-f show Igal Examiner must be notified at	Funeral Directo		<ol><li>Was Decedent Ever Armed Forces?</li></ol>	in U.S. 13.	Was Decedent o	f Hispanic Ori uban, Mexicar	igin? (Specify n, Puerto Ricai	Yes or No- n, etc.)		e - Americ k, White,	
50	s afte	by Fi	1 ☐ Never Married 2 ★ Married : 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2√∑ No If Yes, Give Year or Dates:		1⊡Yes 2√EN	lo Specify:			Specify	/: As	sian
2-0020	fited within 72 hours after Hygiene. sther than "natural", or Ite ent, the Wedical Examine.	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occ	cupation		16	ib. Kind of Br	usiness/Inc	dustry
פ	thin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life.	kind of work dor DO NOT use reti	ne during mos ired)	t of working				
V	ygien ygien ter th	Con	12	4	Home	maker	1.0.11.11			Own Ho		
yland	be de la pe	o Be	17. Father's Name (First, Middle, Last) Doo Sun Chung				1	er's Name <i>(Fir:</i> Shin K		ilden Suman	18)	
	should by	٢	19a, Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Stre				City or Town,	State, Zip	Code)
2	2 6 8 8		Kong Jik Lim - Hush	and	907	Highster	per Tr	rail S	vkesvi	lle. M	arvla	and 21784
ě,	s 1 and of Health item 27 other tr		20a. Method of Disposition	20	Ob. Place of Dispo		-	Date		c. Location -		
Ē	Pages ment of ent: If it ury or o		1 ⊠Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	M	eadowrid	ge Memoi	rial	3/9/04	_ E	lkridg	je, Ma	aryland
Daltimol	permit. Pages Department of I Importent: If its any injury or o		21. Signature of Funeral Service License	е	Ğ 7	2. Name and Add ary L. I 250 Wash	dress of Facilit Kaufmar Ningtor	i Funer n Blvd.	al Home	e At M idge,	MP., Mary]	Inc. Land 21075
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart ailure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the e cause on each line.  Due to lor as a con	ophic 1	-	lying, such as		piratory arrest			Approximate Interval Between Onset and Death
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	ate be executed hysician and the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events									
100/	be executed ician and burial-transit		resulting in death) Last	Due to (or as a cor	nsequence of):							
2/20	icate b physic s the b	dical	d									W 11 11 11 11 11 11 11 11 11 11 11 11 11
C. Box 6	death certif e attending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 U yes 2 No 9 Unknown	lc. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnar Other (specify)				23d. Da Mo	te of delive	ry Day Year
rds, F	w requires that the been signed by th should be detache	b	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	nderlying cause	given in Part I		23e. Did toba 1 ☐ Yes	_		e cause of death? ably 4 □Unknown
Hecord	e law has b	Completed							24a. Was an autopsy performe 1 ☐ Yes 2 5	id,?   (	death?	psy findings available inpletion of cause of 2 No
Vital	Physician: Th r this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					e of Death (Ch	eck only one)			_
Ö	Physic this c	2	1 10s 2 100		2 ER/Outpatie	IL SEI DON		ursing Home	-			1)
	fe er	lon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea		V	vork? □Yes 2□		Describe how	injury occur	90	
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)			28f. L	ocation (Stree City or Town, S	et and Numb State)	er or Rura	l Route Number,
	e Hospital 24 hours a e Funeral letely filled	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my er: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at the vestigation, in m	time, date ar y opinion, dea	nd place, and o ath occurred at	due to the caus the time, date	se(s) and ma a and place,	inner as st and due to	ated. the cause(s)
r	To the within 2 To the Complete	Me	29b. Signatury and title of certifier	roscs		1000	onse number	-	_ ] ′	By S	04	
	6		30. Name and address of person who con	mpleted cause of death	(Item 23a) (Type,		RO	ad (	uthe	rul	le, 1	ND
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's S								
10%	Regist	rar	MAR 0 8 200	14 Desur	J. A.	rester						
DH	HMH 17 Rev 1/2	2001			-							

		1 - For State Registrar	State of Ma		/ Depa	artme		ealth ar	nd Me	ntal Hygi	ene 3. No. 2	004	0694
Physic /Med		1. Decedent's Name <i>(First, Middle, La</i> Barley	LeBa	on					1	Date of Death March	Aay	2004	3. Time of Death  1:30 P M
Exami		4a. Facility Name (If not institution, gir	ve street and number)					_ocation of I	Death			nty of Death	
	98	1944 Bell Avenue  5. Sociat Security Number 6.	Sex 7. Age	e (In yrs. last	hirthday)		letho:	rpe If Under 24	Hrs. 8	. Date of Birth		ltimore 9. Birtho	
Funeral Director		0, 000.2, 000.2,	1□ M 2⊠F	78	Yrs.		Days		Min.	(Month, Day, ) June 4,	1925	LA	lace (State or Foreigr try)
land ow		10a. State 10b. County		10c. City, T	own or Lo	ocation					10d. Inside City		
Many a-1 sh	tor	Maryland Baltimo	ore		Hale	thor	pe						1 ☐ Yes 21⁄2 No
ith the	Director	10e. Street and Number				10f. Z	ip Code					of What Coun	•
death with the Maryland ms 23a or 28a-f show must be reditted at		1944 Bell Avenue	T		140		2122		-2 (Coos)			ed Stat	
<u> </u>	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?  1 Yes 25 N  tf Yes, Give Year or Dates:				ecify Cuban	Mexican, I	n ? (Speci Puerto Ri	ify Yes or No- can, etc.)	E	Black, White,	etc.
hour	ed	15. Decedent's E	ducation	1	6a. Dece	dent's Us	ual Occupa	tion		1	6b. Kind o	f Business/Inc	lustry
ithin 72 hours at ne. han "natural", or a Medical Exard	Completed	(Specify only highest gi	rade completed) Cotlege (1-4or 5	5+)	life.	DO NOT	ork done di use retired)	tion uring most o	ot working				
giene giene th	Com	8			Flor	al D	esigne					Employ	<u>red</u>
ould be filed Mental Hygi arked other	e	17. Father's Name (First, Middle, Lass Benjamin K. Strac	•							First, Middle, M Toodard	aiden Sun	name)	
2 should be in and Mental is marked o	ို				405 14-10		- /C11-				City of To	er Stata Zia	Codol
id 2 shi th and t7 is m treum		19a. Informant's Name/Relationship  Tim LeBon – Son	(Type, Print)			•			100-40	Route Number,			
1 and Health em 2		20a. Method of Disposition					Avenu ame of other place		aletr Dai			212 on - City or To	
ages nt of t: If it		1 🖾 Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Spec	Removal from State	Meado	etery, crei wrid	matory or cre. Mo	other place em . Pa	ark   3	3/8/0	)4 F	lkrid	ige Ma	aryland
permit. Pages 1 and 2 should by Department of Health and Menia Important: If Item 27 is marked any injury or other treumatic encoura		21. Signature of Funeral Service Lice			2'	2 Name	and Address	of Facility				-	
8258		111. 19h			7	250 i	<i>V</i> ashir	ngton	Blvd	. Elkr	idge,	Mary]	Inc. and 21075
Physiciar /Medica Examine		23a. Part1. Enter the disease, or cor shock, or heart failure. List ont Immediate Cause (Finat disease or condition resulting in death)	v one cause on each III	ONA	RY				6	IS EAST			Approximate totaval Between Onset and Death
ate be executed hysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a consequen										
The law requires that the death certificate I the has been signed by the attending physicage 2 should be detached for use as the the state of the st	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	ath 3	⊒Ectopic ⊒ Other (	pregnancy specify)					Date of delive Month	ory Day Year
uires that the de	þ	Part II. Other significant conditions	contributing to death b	ut not resultir	ng in the u	inderlying	cause give	n in Part I.		23e. Did toba	h.		ne cause of death? ably 4 🗀 Unknowr
or Attending Physician: The law requires t after death.  Director: After this certificate has been signer in by the funeral director, page 2 should be to	Completed							_		24a. Was an autopsy perform		b. Were auto prior to con death? 1 ☐ Yes	psy findings available appletion of cause of
ician: Th certificate rector, pag	BeC	25. Was case referred to medical	-					26. Place o	of Death (	1 ☐ Yes 2 Check only one	/	7,3,100	20110
ysici is cer direc	To B	examiner?	Hospitat:	ent 2 ER	VOutpatie	nt 3 🗆 🛭	OCA Othe	r: 4 🗆 Nurs	sing Home	e 5 Resider	nce 6 🗆	Other (Specify	()
nding Physician: th: T: After this certific		27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date of Inju (Month, Da	ry Year) 28	Bb. Time o Injury	of M	28c. Injury Work	at	28	d. Describe how			
within 24 hours after death.  To the Hospital or Attending Physician:  To the Funetal Director: After this certifical completely filled in by the funeral director:	Certification:	3 Suicide 6 Could not 4 Homicide determine	A 286. Place of In	ury - At home c. (Specify)	e, farm, st	reet, facto	ory, office		28	Bf. Location (Str. City or Town,		imber or Rura	l Route Number,
ne Hospita 124 hours ne Funeral detely filled	Medical (		Physician: To the best aminer: On the basis o and manner st	f examination									
· - `	2 2	29b. Signature and title of certifier	4 011	1	21		9c. License		7 2			ned (Month,	
.9		30. Name and address of person wh		death (Item 2: 4994	3a) (Type.	Print)	BON	OR EI	5	column	BIA.	MARY	ILAND
	itate	31. Date filed (Month, Day, Year)	32. Registr	rar's Signatur	0	a luch	e no	1					
* S Regis			32. Registr	rar' Signatur	٠ ا	e A		,					

DHMH 17 Rev 1/2001

Common			#10b&State of Maryland / Depart 1- State RegistrarAMEND ITEM #4c PER PHY G829 3/22/04@Arti		lental Hygie Reg.	ne N2004 06942
Clement Jordan Lipscomb  Clement Jordan Lipscomb  Control Season Service Water and number   45.25 Cranherry Court   45.09, Fown or Location of Death   45.09, Fown or Location   45.09, Fown or Loc	- ·		Decedent's Name (First, Middle, Last)			Day Year
4. Specified protection of Death   4. County of Deather Y County   1. County			Clement Jordan Lipscomb		February	24, 2004 4:20 P.
2 Source Security Number 2 Source Security Num			4a. Facility Name (If not institution, give street and number)	b. City, Town, or Location of Death		
Direction    Comparison   Compa						
The state of the company of the comp			229-32-8658 YDM 2DF 73 Yrs.		8. Date of Birth (Month, Day, Ye March 15,	ar) 9. Birthplace (State or Foreig Country) Virginia
The Device of the Control of Section   The Device of th	and	}		tion		10d. Inside City Limit
Physician   Phys	Manyl f sho	ō	MD Hanover			1 ☐ Yes 2X N
Post Commence   Program	the 1	ect	MID HOWARD HAHOVEL	10f. Zip Code	10g.	Citizen of What Country?
Section   Processing   Proces	3a or	0	7525 Cranberry Court	21076	τ	ISA
Bennie A. Lipscomb   Television   Televisi	death	ner		as Decedent of Hispanic Origin? (Spe	ecify Yes or No-	
Bennie A. Lipscomb   Tenher's Name (First, Modife, Last)   Susie B. Lawhorn   State Susie B. Lawhorn   Sus	urs after al', or ite	þ	1 Never Married 2 Married 1 TYPes 2 No		ricari, otc.)	7.7h + -
Bennie A. Lipscomb   Television   Televisi	72 ho	ted	15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give kir	nt's Usual Occupation	na 16b	. Kind of Business/Industry
1.08-brief   2   Ceremation   3   Ceremation   1.08-brief   2   2.08   2.004   2.08   2.004   2.08   2.004   2.08   2.0	thin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)			
1.08-brief   2   Ceremation   3   Ceremation   1.08-brief   2   2.08   2.004   2.08   2.004   2.08   2.004   2.08   2.0	ed wi	S				
1.08-brief   2   Ceremation   3   Ceremation   1.08-brief   2   2.08   2.004   2.08   2.004   2.08   2.004   2.08   2.0	uid be fill Aentai H rked ott tic even	Fo Be				
1.68-brial 2   Cremation   Specific   Spec	d 2 sho Ith and h 27 is ma trauma	0 1				
Physician //Medical Exeminer  Physician //Medical Exeminer Physician //Medical Exeminer Physician //Medical Exeminer Physician	ges 1 ar it of Hea if item or other	i ii	20a. Method of Disposition  1 A Burial 2 Cremation 3 Removal from State  20b. Place of Disposition cemetery, cremation	ion (Name of tory or other place)	Date 20c	. Location - City or Town, State
Physician //Medical Exeminer  Physician //Medical Exeminer Physician //Medical Exeminer Physician //Medical Exeminer Physician	tmen tant: ijury	1 1				
Physician / Medical Examiner  Physic	Deparmination of the part of t		1101236			-
Physician   Medical Examiner	=		- Nage of			
Sequentially list conditions. If any, leading to immediate class (Disease or right) that intiated events resulting in death) Last    Chronic Obstructive Lung Disease   Due to (or as a consequence of):			Immediate Cause (Final disease or condition resultion in death)  Respiratory Failur			Interval Between Onset and Death
The part of the pa			Chronic Obstructive	ve Lung Disease		
d	pe jist	niner	if any, leading to immediate cause. Enter Underlying			
9 Unknown  9 Unknown  9 Unknown  9 Unknown  9 Unknown  9 Unknown  9 Unknown  9 Unknown  9 Unknown  9 Unknown  9 Unknown  23a. Did tobacco use contribute to the cause of or known and prior to completion of cleath?  1 Ves 2 No 3 Probably 4 Death?  24a. Was an autopsy performed? 1 Ves 2 No 1 Ves 2 N	be execut sician and burial-trar		that initiated events			1
9   Unknown   9	rtificate ng phys as the	0	O.			
Yes 2   No 3   Probably 4	the attendi	/sician/	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 12 No 15 No 17 No 17 No 18 N			
24a. Was an autopsy findings prior to completion of clearth?  1	that If ed by detac	/ Ph		erlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
24a. Was an autopsy findings prior to completion of clearth?  1	quires an sign uld be	d pa			X Yes	2 No 3 Probably 4 Unknow
25. Was case referred to medical examiner?  1	s bee	ojet				24b. Were autopsy findings availab
25. Was case referred to medical examiner?  1	The la	E			performed	? death?
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	riffica	a		26. Place of Death		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier 29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	nysic	0		3 □ DOA Other: 4 □ Nursing Ho	me 🎖 Residence	6 ☐Other (Specify)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier 29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	ding After fune			Work?	28d. Describe how in	njury occurred
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier 29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	al or Atter s after dea ni Director ed in by the	Sertifica	3 Suicide 6 Could not be	t, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	e Hospit 24 hour s Funera eteky fille		(Check only 2 Medical Examiner: On the basis of examination and/or inves			
E SU POVII IVAN	omple	Me		29c. License number	29d.	Date signed (Month, Day, Year)
D3192/ February 26, 2004	->-0		by minimus	D31927	Feb	ruary 26, 2004
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	, MY		30. Name and address of person who completed cause of death (Item 23a) (Type. Pri	int)		
Ho-Lai Feng, M.D. Two Knoll North Drive, Columbia, Maryland 21045	10				ryland 21	.045
State Registrar  31. Date filed (Month, Day, Year)  AR 0 8 2004  32. Registrar's agnatury	Sta	te			,	

			1 - For State Registrar  1. Decedent's Name (First, Middle, Las		Maryland / De	partmen ertificat				, ,	eg. No.	20	04	0694
	Physici		Dorothy Reed Lar	-						Month	Day		ear 7	0 830 AM
)	/Medic Examir		4a. Fecility Name (If not institution, give ST. AGNES HEAL	street and numi		4b. City, BA	Town, or	Location of	f Death	, , , , , ,	7	County of		0000
¥.	Funeral Director		5. Social Security Number 216-05-7362 6. Security Number 216-05-7362	x 7 □M 2⊠F	. Age (In yrs. last birthdi 85 <sup>Yrs</sup>	Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Day June 1,	Year) 191	8 V	Birthpl Count 1rg	ace (State or Foreign ry) inia
	ould be filed within 72 hours after death with the Maryland Mental Hygiene.  arked other than "natural" or Items 23e or 28e-f show after event, the Moultal Expredies runal by notified at	ctor	10a. State 10b. County  Maryland Baltin	nore	10c. City, Town or	Location nsvill	Le						10	od. Inside City Limits 1 ☐ Yes 2 ☒ No
	vith the	Maryland   Baltimore   Catonsville   10e. Street and Number   10f. Zip Code   10g. Citize   717 Maiden   Choice Lane Apt 510   21228   11. Marital Status   12. Was Decedent Ever in U.S. Armed Forces?   1   Yes, specify Cuban, Mexican, Puerto Rican, etc.)   14. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)   14. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)   15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)   15. Was Decedent Ever in U.S.   15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)   15. Was Decedent Ever in U.S.									en of Wha	at Count	ry?	
	eath v	eral	/I/ Maiden (						in? (Sna	city Ves or No-		U.S.		n Indian
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Musical Experient mark the notified at ance.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? ! 🔯 No	If Yes, spe		Specify:	Puerto F	cify Yes or No- Rican, etc.)			White, e	tc.
S O	72 ho	eted	15. Decedent's Edi	ucation de completed)	(G	cedent's Usu	rk done a	turing most	of workin	a	16b. Kind	of Busin		
121215-0036	led within lygiene. her then "	Completed	Elementary/Secondary (0-12)	College (1-4	for 5+)	cretar	se retired	)		D	epar	t of		ryland alth
Maryland	should be fi ind Mental H marked off umatic ever	To Be	17. Father's Name (First, Middle, Last) Walter Reed							(First, Middle, I le Lank		umame)		
Mar	d 2 sho h and 7 is m traum	13	19a. Informant's Name/Relationship (T							Route Number				
Baltimore,	Pages 1 and ment of Health ant: If item 27 ury or other tr		Robert E. Landaue  20a. Method of Disposition  1 & Burial 2 Cremation 3 Disposition		20b. Place of Dis	Malde sposition (Nar rematory or o	en Ch me of other place	oice		Catons		e M ation - Cit		
altim	mit. Pa bartmen portant: r injury		*4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens		Druid R					2004 ] of Cato	Balt:	imore	e, M	aryland
m	Depa Impo any io		MAN	MO	0869	630 Ed	mond	son A	ome ve C	of Cato atonsvi	nsvı 11e,	Mar Mar	ınc y <u>lan</u>	d 21228
*	Physician /Medical		236 Part1. Enter the disease, or comp book, or hear failure. List only of Immediate Cause (Final disease or condition resulting in death)	a.	Premo		le of dying	, such as c	ardiac or	respiratory arre	est,			Approximate Interval Between Onset and Death
J	Examiner		Sequentiathy list conditions	Due to (o:	r as a consequence of):									
	uted d ansit	Examiner	if any, leading to immediate cause. Enter or certaining Cause (Disease or injury		ras a consequence of):									
8760,	ate be executed hysician and the burial-transit	cal	resulting in death) Last		r as a consequence of):						· · · · · ·		i i	
P.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ™No 9 □ Unknown	1 Live birt	nt at time of death	3 □Ectopic pr 5 □ Other (sp					23	d. Date o Month		/ Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to dea	th but not resulting in the	underlying c	ause give	n in Part I.						cause of death?
Il Records,		Completed								24a. Was ar autops perform 1 Yes 2	y .	prior deat	r to com	sy findings available pletion of cause of
Vital	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital Ing			Othe			(Check only one				
Division of	ng Ph fter th meral	tlon: To	27. Manner of Death Natural 5 Pending	28a. Date of			8c. Injury Work	i 4 □ Nurs at ? ′es 2 □ N	28	e 5 Reside			Specify)	
Divisi	I or Atten after deat Director: I in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place o building	f Injury - At home, farm, , etc. (Specify)					3f. Location (Str City or Town	reet and I , State)	Vumber o	r Rural i	Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  Certifying Phy 2 Medical Exami	sician: To the b ner: On the bas and manne	est of my knowledge, de is of examination and/or r stated.	ath occurred investigation,	at the tim in my op	e, date and inion, death	place, ar	nd due to the ca	use(s) ar	nd manne ace, and	r as stat	red. he cause(s)
•	To th withir To th comp	Me	29b. Signature and title of certifier	v~D		290	License	number	)			signed (N		
	M		30. Name and address of person who c	ompleted cause	of death (Item 23a) (Typ	e Print)		ane	( G	lens Vil				ows
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 8		gistrar's Signature	G	Son	aki s				- 0	Α.,	-/
					/	1	1							

DHMH 17 Rev 1/2001

LANDAUER

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DOROTHY

			1 - For State Registrar	State of Mai		artment of F		Mental Hyg	iene g. No. 200	4 06941	
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last)     JOHN McFA      A. Facility Name (If not institution, give	LL		4b. City, Town, or	r Location of Deat	2. Date of Deat Month MARCH	Day Year	3. Time of Death 10:29a M	
	Funeral	) 	Manor Care - Fa	lls Road	(In yrs. last birthday)	Balt:	imore If Under 24 Hrs.	8. Date of Birth	N/A	thplace (State or Foreign	
ę	Director		Usual Residence of Decedent	<b>%</b> M 2□F	93 Yrs.	Months Days	Hours Min.	(Month, Day, Aug. 11	Year) C	S.C.	
	the Marylan 28e-f show	rector	10a. State 10b. County 10b. County 10b. Street and Number 10b. County 10b. Cou		Baltim			11	0g. Citizen of What C	10d. Inside City Limits 1 □XYes 2 □ No	
36	72 hours after death with the Maryland natural', or Itams 23a or 28e-f show neal Examiner mat be notified at	by Funeral Director	11 W. 20th Stree	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13.	2121 Was Decedent of H If Yes, specify Cuba			U.S.A.		
21215-0036	d within 72 hou giene. er than "nature in the Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wor	king	16b. Kind of Business		
Maryland	ould be file Mental Hy karked othe latic event,	O	17. Father's Name (First, Middle, Last) Sam McFall				Amel	ne (First, Middle, A ia White	Maiden Sumame)		
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28e-1 show any injury or other treumatic event, the Marchal Examiner mast be notified at once.		19a. Informant's Name/Relationship (Ty, Betty Joe Dixon- 20a. Method of Disposition 1 Surial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Sign to e of Funeral Service Lensing	-Daughter lemoval from State	20 Se 20b. Place of Dispo cometery, crer Salem Ce	enter La sition (Name of natory or other place emetery 2. Name and Address	ane, Bunn 3/11 as of Facility Nu	nlevel, Date /04 Entter Fu	ineral Ho	23 Town, State County, S.	
	Physician /Medical Examiner	ılner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a c	PSIS					Approximate Interval Between Onset and Death	
). Box 68760,	Attending Physician: The law requires that the death certificate be executed rideath.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a of the control of th	pregnancy □ Fetal death 3 □	Ectopic pregnancy		115 V z	23d. Date of del Month	ivery Day Year	
rds, P.O.	quires that the n signed by t uld be detach	þ	9 Unknown  Part II. Other significant conditions con  PATERT B	atributing to death but in	not resulting in the u	nderlying cause give	en in Part I.		acco use contribute to	the cause of death?	
al Reco	ysician: The law requir Is certificate has been si director, page 2 should I	Completed						24a. Was an autopsy perform	prior to o	topsy findings available completion of cause of	
Division of Vital Records,	nding Physicial ath. r: After this certil ie funeral directo	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No H  27. Manner of Deuth 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 Nursing H	th Check only one ome 5 Resider 28d. Describe how	nce 6 Other (Spec	cify)	
Divis	Dir.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, str (Specify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,	
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	one)	sician: To the best of rate: On the basis of each and manner states	camination and/or inv	estigation, in my op	inion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)	
	To vith	2	29b. Signature and title of certifier  30. Name and address of person who co	M ·	D .		5845F		ARCI+ 5		
	Sta	te	Nana Ceasar 821 31. Date filed (Month, Day, Year)	N. Euta	W St. Ba		, MD 21	229			
	Registr	ar	MAR 0 8 2004	Bours	1 1.	· · · · · · · · · · · · · · · · · · ·					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2004 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day MARCH 04 2004 **Physician** MOHR 5:15 P M MARGARET /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL CO. SEVERNA PARK GENESIS ELDERCARE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1 ☐ M 2 🛱 F 88 Yrs. **Director** 216-03-5540 March 16 1915 Maryland Usual Residence of Decedent 10d. Inside City Limits with the Manyland 10b County 10c. City. Town or Location 10a. State s 23a or 28a-f show ust be notified at 1 ☐ Yes 2 ☑ No Md. Anne Arundel Co. Glen Burnie Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 7900 Benesch Circle Apt. 789 21060 U.S.A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates: filed within 72 hours after 1 Never Married 2 Married 9 1 ☐ Yes 2 № No Specify: Baltimore, Maryland 21215-0036 Specify: white event, the Medical Exam ģ 3 Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then College (1-4or 5+) Elementary/Secondary (0-12) Housewife Own Home 8 0 other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be if Health and Mental Pages 1 and 2 should be Quasky Frederick Agnes Neal1 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah W. Robinson (Daughter) 2954 Beaver Brook Court, Pasadena, Md. 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cedar | Hill Cemetery | 03/08/2004 Baltimore, Md. 22. Name and Address of Facility Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensee once. 3204 Mountain Road, Pasadena, Md. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath inmediate Cause (Final disease or condition resulting in death) everhoura Meta slake Physician /Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day detached for 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 8 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 X No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification; To this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical completely (Check only one) and manner stated. within 2 To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21684 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O.V. CYRIAC-M-D 8021 RITEGHE II 8021 RITCHIE WY, PASADENA, 32: Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 8 2004 Registrar

	State of Ma		tment of Hea ificate of De	alth and Mental H eath	ygiene Reg. No. 20	104 06946
	1. Decedent's Name (First, Middle, Last)			2. Date of I		3. Time of Death
Physician /Medical	THOMAS MOORE			MANC	1	704 1415
Examiner	4a Facility Name (If not institution, give street and number)		4b. C	City, Town, or Location of De	ath 4c. County	of Death
	STELLA MARIS HOSPICE @ MERCY HOSE	PITAL		BALTIMORE		NA
Funeral	5. Social Security Number 6. Sex 7. Age 1 1 1 1 2 1 F	()		Under 24 Hrs. 8. Date of I	Birth Day, Year)	Birthplace (State or Foreign Country)
Director	244-02-12/4	44 Yrs.		OCT 15		MD
and *	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loca	ition			10d. Inside City Limits
Aarylan f show	MD NA	BALTIN				1⊠Yes 2□No
vith the Maryle or 28a-f sho be notified at Director	10e. Street and Number	DALLI	10RL 10f. Zip Code		10g. Citizen of V	Vhat Country?
A P P				7		
Ifer death v	320 S. FULTON AVENUE 11. Marital Status   12. Was Decedent B	Ever in U,S. 13. Wa	2121. as Decedent of Hispa	/ nic Origin? (Specify Yes or l /lexican, Puerto Rican, etc.)		ISA e - American Indian,
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<b>5 1 1 1 1 1 1 1 1 1 1</b>	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	11.	JYes 2∭X No S	pecify:	Specify	AMERICAN
MUONCO 121215-0020 led within 72 hours after death with the Manyland yagiene. The Medical Examiner must be notified at it, the Medical Examiner must be notified at Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. Deceder	nt's Usual Occupation	n most of working	16b. Kind of Bu	siness/Industry
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aryland should be in marked of umatic eve	ABRAHAM MOORE	T		SHIRLEY MAE		
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Ore, Maryland ges 1 and 2 should be file to fleatin and Mental Hy it for the art is marked othe or other traumatic event. To Be C	JAMES MOORE (COUSIN) 20a. Method of Disposition	320 S	FULTON AVEN	NUE BALTIMORE, Date		City or Town, State
Pages ient of l	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crema	tory or other place)			
Baltimore, Jeani: Pages 1 at J	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	METRO CREMA	VIORY Name and Address of	3/4/04	CATONSVIL	
Baltimore, Permit Pages 1 and Department of Health Department of Health Department of Health Department of Health Step Step Step Step Step Step Step Step	21. Signature of Pulletan Service Licensee	~		MILTE LONG		
	I MI LUM			STREET BALTIMO		
	23a. Part . Enter the disease, or complications that caused shock, or heart failure. List only on cause on each lin	ne.	the mode of dying, st	uch as cardiac of respiratory	allest,	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final		1	1 (		
Examiner	disease or condition resulting in death) a.	o your		deficiency	22196m	
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O, execution and an article in the control of the c	Sequentially list conditions, if any, leading to immediate ceuse. Enter Undertying Cause (Disease or injury					
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al Record The law require rate has been si page 2 should						of death?
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inon ation	1 ☑Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	(Year) Injury		2 🗆 No		
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			State of Maryland / Department of Health State Registrar  State Registrar	alth and Mental I	_	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Theresa A. Maurer	2. Date of Month Marc	Death Day	3. Time of Death
3.1	Funeral Director			SON f Under 24 Hrs. 8. Date of Hours Min. (Month.	4c. County of  Baltin Birth Day, Year) h30,1930	Ore  Birthplace (State or Foreign Country)
10 35 N	death with the Maryland ms 23e or 28a-f show	ctor	Usuel Residence of Decedent           10a. State         10b. County         10c. City, Town or Location           MD         Baltimore         Essex	, ", ", ", ", ", ", ", ", ", ", ", ", ",		10d. Inside City Limits 1 ☐ Yes 2 No
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	je	by	11. Marital Status  1 Never Married  2 Married  3 Was Decedent Ever in U.S. Armed Forces?  1 Yes, Specify Cuban, North Press, Give Year or Dates:  13. Was Decedent of Hispart If Yes, specify Cuban, North Press, Give Year or Dates:	anic Origin? (Specify Yes or Mexican, Puerto Rican, etc. Specify:	No- 14 Race- Black, Specify:	American Indian, White, etc. White
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			19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and 305 Savannah	Rd. Essex 1	MD. 21221	
Dauyer Baltimore.	Page nent c		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  OakLawn Cemetery  21. Signature of Funeral Service Licensee			ore,Maryland
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recto	o De	25. Was case referred to medical examiner?	lospital:	O 5000	t all pos Oth		ath (Check only or			
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detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time of 1 Unknown	etal death 3 [ of death 5 [	Ectopic pregnancy Other (specify)		22e Did to	М	ate of deliver	Day Year
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marke.	0	Albert Samu		Morgan		Kati		ay	Jor	
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ma 23	Funeral Director	1900 Rosemont Av	12. Was Decedent Ever in		Was Decedent of I	702 Hispanic Origin? (	Specify Yes or No	U.S.	A. ace - Ameni	can Indian,
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neral ector		5. Social Security Number 6. Se	7. Age (In )	yrs. last birthday, 84 Yrs.		If Under 24 Hr	. (Month, Da	th v. Year)	9. Birth Cou	place (State or F intry)
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	9	Decedent's Name (First, Middle,	Last)							2. Date of Dea Month		Year	3. Time of Death
Physicia /Medic		Dorothy Emma M	vers							Mar.	3	2004	2:35PM M
Examin		4a. Facility Name (If not institution,	give street and nu			,,		Location o				ounty of Death	
		Genesis Elderca						re Co				Baltin	
Funeral Director		220~30~4436	3. Sex 1 □ M <b>2/CX</b> F	7. Age (In yi	rs. last birthday) Yrs.	If Under Months		If Under: Hours	Min.	8. Date of Birth (Month, Day Nov. 8	r. Year)	9. Birthin Couil	place (State or Foreign htry) cyland
and **	}	Usual Residence of Decedent  10a, State 10b, County		10c.	City, Town or Lo	cation						1	10d. Inside City Limits
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ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland the Hygiene. d other than "naturel", or Itema 28a or 28a-f show d other than "naturel", or Itema 28a or 28a-f show event, I're Medical Examinar must be notified at	ted	15. Decedent's	Education		16a. Dece	dent's Usua	al Occupa	ition	4 = 6		16b. Kind	d of Business/In	dustry
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2 - 2 2	2	Edward Laubach  19a. Informant's Name/Relationshi	ip (Type, Print)		19b. Maili	ng Address	(Street a			ne Minn:			Code)
Mai nd 2 st with and 27 Is n r traun		Marlene Fields		r)		317 (	reyh	nound	Rd.	Baltimo	ore,	Md. 212	221
s 1 ar		20a. Method of Disposition		01-1-1	D. Place of Dispo cemetery, cre	matory or o	ther plac	e)		Date	20 <b>c</b> . Loca	ation - City or To	own, State
Pages nent of I		1 N Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.	3 ∐Hemoval from ecify)	Ga	ardens d	of Fai	ith (	Cem.¦∶	3~6~	2004	Balti	more, M	1d.
SAITIMOF Demit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service L	icensee	ncki	2:	Lassa 7401	Addres	s of Facilit Unera	il Ho	ome altimore	e. Md	. 21236	
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/ 60, le be executed ysician and le burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a cons	sequence of):							-	
four	cal		d										
rtifical	Med	IF FEMALE:											
Hecords, P.O. Box 68 (1) The law requires that the death certificate I the law seen signed by the attending physion age 2 should be detached for use as the land.	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pre- birth 2 1 F gnant at time of	etal death 3[	⊒Ectopic pr ⊒ Other (sp					23	3d. Date of deliv Month	ery Day Year
by the c	iysic	1 □ Yes 2 ▼No 9 □ Unknown	9□Unk		n death St	_ Other (sp	deliy)						
that the hed by deta		Part II. Other significant condition	ns contributing to	death but not	resulting in the u	inderlying c	ause give	en in Part I	l.	23e. Did to	bacco us	e contribute to t	he cause of death?
COTGS, P wrequires that been signed b should be deta	ed by									101	es 2 💢	No 3□Prol	bably 4 Unknown
VI(al HECOTGS, sicien: The law requires t certificate has been signe rector, page 2 should be continued.	Completed									24a. Was		24b. Were auto	opsy findings available ompletion of cause of
	Com									perfo	med? 2 No	death? 1 ☐ Yes	20 No
t VItal H ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?	Manadali				044		of Deat	h (Check only o	ne)		
Physi Physi this o	2	1 ☐ Yes 2 No 27. Manper of Death	h-	Inpatient 2 e of Injury	2 ER/Outpatie			4 00 NL	ursing Ho	me 5 Residence 128d. Describe h			fy)
ding I	tion	1 Natural 5 ☐ Pending	(Mo	onth, Day Year	njury	M	28c. Injun Worl	k?" Yes 2⊟	No	Zod. Describe i	iow injury	occurred	
DIVISION OF To Attending Phy after death. Director: After this sin by the funeral d	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Plac	ce of Injury - A	t home, farm, st	reet, factor		V History		28f. Location (S	Street and	Number or Rur	al Route Number,
DIV all or /	Certification:	4 Thomicide	buil	ding, etc. (Sp.	ecity)					City or Tox	vn, State)		
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific; completely filled in by the funeral director.	edical (		Physician: To the examiner: On the and ma										
To th within To th compl	Me	29b. Signature and title of certifier	Par	shell	ond.			e number	08			signed (Month,	1
15		30. Name and address of person v	who completed ca	use of death (	Item 23a) Fype		- 1						
13			HALL				N	5 00%	ARE	DR.	BALT	HORE	MD.
	ate	31. Date filed (Month, Day, Year)	9 200 4							7			,
Regist		man u	8 2004	RIKIRIAR	13	Ansel	Serve 9						<del></del>

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of rtificate of	Health and Death		iene 20	04 06950
Ì	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Roger William Ma					2. Date of Deat		3. Time of Death
	Examir		4a. Facility Name (If not institution, give s 3420 Northpoint	Road		Dur	or Location of De Idalk			Deeth imore
	Funeral Director		5. Social Security Number 220-66-2211 6. Sex		(In yrs. last birthday, 47 Yrs.	Months Days			Year) , 1956	B. Birthplace (State or Foreign Country) Maryland
	Maryland B-f show	tor	10a. State 10b. County MD Baltimo		10c. City, Town or L Dund					10d. Inside City Limits 1 ☐ Yes 2√☐ No
	th with the 23a or 28	ai Director	10e. Street and Number 3420 Northpoint F	Road		10f. Zip Code	1222	10	g. Citizen of Wh	at Country?
920	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "naturel, or itams 23a or 28a-f show aumatic event, the Medical Examiner must be invitilled at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 No		(Specify Yes or No- erto Rican, etc.)	14. Race -	American Indian, White, etc. White
Maryland 21215-0036	within 72 ho ene. then "natur the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of ward)	vorking	6b. Kind of Busin	
/land 2	uld be filed Mental Hygi krked other atic event, L	To Be Co	17. Father's Name (First, Middle, Last)  James Ray Main	0	1	supervis	18. Mother's N	ame (First, Middle, M	laiden Sumame)	ng companies Tmick
Σ	and 2 sho ealth and in 27 is mu		19a. Informant's Name/Relationship (Ty) Darlene Main/sp					Rural Route Number, l Dundalk,		
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic e age.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  '4 ፟ Donation 5 ☐ Other (Specify)	/1		matory or other pla	. I			ty or Town, State
Bal	permit. Departr Importa eny inje		21. Signatur of Fyneral Service Licenses	Medica	De	ircimore,	MD = 212			re Street
	Physician /Medical Examiner		23a. Pant . Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	consequence of):	_			st,	Approximate Interval Between Onset and Death
8760,	death certificate be executed attending physician and e attending physician and idlor use as the burial-transit	dicai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
O. Box 6	at the death certitic by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[ Yes \ 2 \] No 9 \[ Unknown \]	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	]Ectopic pregnand ] Other <i>(specify)</i> _	у		23d. Date of Month	
ecords, P	signed d be de	ρχ	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did toba		ite to the cause of death?  Probably 4 Unknown
Υ,	The law ate has b page 2 st	Completed						24a. Was an autopsy perform	ed? prio	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
VITal	Physician: Th this certiticate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:		- 101		eath (Check only one		
n or	ding Phys h. After this tuneral di	$\vdash$	1 ☑Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 ☐ Inpatient 28a. Date of Injury (Month, Day	2 ER/Outpatier 28b. Time of Injury	28c, Inju	4 🗆 Nursing	Home 5 Resider 28d. Describe how		(Specify)
UIVISION	Atten	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, str (Specify)		]Yes 2□No	28f. Location (Stre City or Town,	et and Number o State)	or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	edicai	29a. Certifier 1 ☑ Certifying Phys (Check only one)	ician: To the best of er: On the basis of e and manner state	xamination and/or in	occurred at the fivestigation, in my o	me, date and place opinion, death occ	ce, and due to the cau curred at the time, dat	ise(s) and manne e and place, and	er as stated. I due to the cause(s)
	To the transfer of the transfer of the transfer of the transfer of	Σ	29b. Signature and title of certifier	edury.	4.D.	29c. Licens	9559	290	Date signed (A	Nonth, Day, Year)
			30. Name and address of person who con  ARRY WATERA  31. Date filed (Month, Day, Year)	mpleted cause of dea	JABA	Print) C 494	O Easke	on ave	, Bali	L. Ad. 21224
	Sta Registr		MAR 0 8 20		a Signature	Cook of	•			

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mar	yland	/ Depa	artment of F rtificate of	lealth and Death	d Mental Hy	giene 20	04 06951
	Physici /Medic		1. Decedent's Name (First, Middle, La John Frederic	•					2. Date of De Month MARCH	Day Y	ear 1015 AM
	Examin Funeral Director		4a. Fecility Name (If not institution, given Union Memorial  5. Social Security Number 6. S 219-05-8951	Hospital	'In yrs. las	t birthday) Yrs.	4b. City, Town, or Ba	1timore	Irs. 8. Date of Bir	ay, Year)	
in	ס		Usual Residence of Decedent  10a, State 10b, County			Town or Lo	cation		pandary	1,1921	10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f ehow rmst. Le notified at	tor	Maryland Baltimo	re		Cator	sville				1 ☐ Yes 2 ☑ No
	or 284	Director	10e. Street and Number		-		10f. Zip Code			10g. Citizen of Wha	at Country?
	na 23a	Funerai	5 Shepherd Hous	e Court  12. Was Decedent Ev	er in U.S.	13.	2122 Was Decedent of H		(Specify Yes or No	U.S.A	American Indian.
2-0030	n 72 hours after death with the Marylan *natural; or Items 23s or 28s-1 show solical Examires must be notified at	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ⊠Yes 2 □ No If Yes, Give Year or Dates:			f Yes, specify Cub 1 ☐ Yes 2 🔼 No	Specity:	(Specify Yes or No erto Rican, etc.)	Black, Specify:	White, etc. White
712-0	within 72 ho ene. then *natur ne Modice! I	Completed	15. Decedent's E. (Specify only highest gra	ducation ide completed) College (1-4or 5+)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of v d)		16b. Kind of Busin	
7	e filed will Hygien other the		17. Father's Name (First, Middle, Last,	4	D.	ulane	y-Vrnay		g Company	Owner-S	elf Employed
yland	s 1 and 2 should be filed withi I Health and Mental Hygiene. Item 27 Is marked other then other traumatic event, Item	To Be	John H. Mille						etta Bitt		
מ	2 should be and Mental Is marked raumatic ev		19a. Informant's Name/Relationship (	Туре, Print)		19b. Mailir	ng Address (Street	and Number or	Rural Route Numb	er, City or Town, Sta	ite, Zip Code)
e e	s 1 and 2 if Health item 27 I		Frances P. Mille 20a. Method of Disposition	r (Wife)	20b. Plac	e of Dispo	sition (Name of		Catonsvi Date	11e, MD 2	
o E	Pages lent of nt: If it ry or c		1 🖾 Burial 2 ☐ Cremation 3 ☐ *4 ☐ Donation 5 ☐ Other (Specif				natory or other pla irk Cemet		6-2004		. Maryland
рант	permit. Pages. Department of I Important: If ite any injury or of once.		21. Signature of Funeral Service Licer	1500		Wi	Name and Addre	ss of Facility eral Hor	me of Cat	onsville.	Inc. Maryland 21228
8100,	bhysician and physician and street in the burial-transit super purial transit super periods and physician and phys	edicai Examiner	23a. Pact. Enter the disease, or com shock, or treart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate auss. Enter Undertryiting Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	PSI consequer	Do not ent  S nce of):					Approximate Interval Between Onset and Death
O. Box oc	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal de	ath 3	Ectopic pregnancy	1		23d. Date o Month	f delivery Day Year
cords, P.	w requires that the been signed by the should be detache	þ	Part II. Other significant conditions of	ontributing to death but	not resulti	ng in the u	nderlying cause giv	en in Part I.			ite to the cause of death?  Probably 4 []Unknown
Heco	tas b	Completed		· · · · · · · · · · · · · · · · · · ·					24a. Was autop perfo	rmed? deat	re autopsy findings available r to completion of cause of th? Yes 2
VII	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		_	Oth		eath (Check only o		
ou o	ng Ph ifter th ineral	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day )		VOutpatien 3b. Time of Injury	28c. Injur Wor	y at k? Yes 2 No	Home 5 Resident	dence 6 Other (	Specify)
DIVISION	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined		- At home (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Number own, State)	or Rural Route Number,
	e Hospita 24 hours e Funeral letely fille	edical C	29a. Certifier 1 certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of eniner: On the basis of en and manner state	kamination	edge, death n and/or in	n occurred at the tir restigation, in my o	ne, date and pla pinion, death oc	ice, and due to the courred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signed (N	fonth, Day, Year)
	12+1		30. Name and address of person who			3a) (Type,	Print) 49 69	COLUM	946 P	MARCH D AD APAR	3 2004 ETHENT # 304
ľ	Sta	te	31. Date filed (Month, Day, Year)	FUSELTE 32. Registrar's	s Signatur	е			NAKYL	AND 2	1047
	Registr	ar	MAR 0 8 200	A Breeze	N	19	South	1 7			

DHMH 17 Rev 1/2001

424104				1 - State Registrar  1. Decedent's Name (First,	Middle 1-				С	ertifica	e of l	Death	7	ental Hyg	leg. No.		06952
8		Physici	an .	Virginia										Month Februar		2004	4:15 PM <sup>M</sup>
4		/Medic Examin	_	4a. Facility Name (If not ins			mber)			4b. City	Town, or	Location				unty of Death	
2	40	LAUIIIII		Gilchrist	Cent	er					owso					altimo	
Town		Funeral Director	y)	5. Social Security Number 262-05-5721		ex □M 2 <b>X</b> F	7. Age	90	last birthda Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Feb 18,	1914	9. Birthi Cou Utal	place (State or Foreign ntry) 1
2		and and		Usual Residence of Deced				10c. Cit	y, Town or	Location							10d. Inside City Limits
inginia		ith with the Maryland 23a or 28e-f show	tor	MD B	altim	ore			То	wson							1 ☐ Yes 2X☐ No
8	>	or 28e-f	Funeral Director	10e. Street and Number						10f. Zi	o Code				10g. Citizen	of What Cou	ntry?
5		5 53 €	erall	204 E. Jopp	a Roa	ad #1003		Ever in U	S. 1	3 Was Dece	212		rigin? (Spec	cify Yes or No-	14.	USA Race - Ameri	can Indian,
S	(0		Fun	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2[</li></ul>	Married	Armed Fo	orces? 2 [☑ N			If Yes, spe				cify Yes or No- lican, etc.)		Black, White,	
artin	036	within 72 hours atter ane. than "natural", or Ite	by	3 ₩ Widowed 4 □ Dir		If Yes, Gr Year or D	ve Dates:						/· 			ecify: whi	
E	15-(	n 72 h	Completed	(Specify only		ide completed)			16a. De (G.	cedent's Usu ve kind of w b. DO NOT t	ial Occup ork done i ise retired	ation during mo d)	st of workin	g	16b. Kind o	of Business/In	dustry
	212		omb	Elementary/Secondary (	0-12)	College (	1-4or 5	+)		inanc					Hopk	ins Ho	spital
	pu	be filed Ital Hygid of other	BeC	17. Father's Name (First, M										(First, Middle,			
	yla	should be nd Mental marked c	70	Edwin Lec		•			10h M	uling Addrag	c (Street			delaide			Code)
	Mar	d 2 th a th a tree tree		19a. Informant's Name/Re Carol Wessr						-				altimor	-		
	ore,	of Health of Health fitem 27		20a. Method of Disposition		Removal from	S/Alla	20b. F	Place of Dis semetery, o	position (Na rematory or	me of other plac	<b>xe</b> )	Da	ate	20c. Locati	ion - City or To	own, State
	Baltimore, Maryland 21215-0036	Pagent nt: I ry o		`4 X Donation 5 □ O	her (Specil	y) /				22. Name a	nd Addre	ss of Faci	lity				
	Bal	permit. Departm Importe any inju		21. Signature of Funeral S RODE	Id S.	Wade,	Vir	ector			Anat	omy I		655 W.	Balt	imore S	Street
	4	京 東 横		23a. Part1. Enter the dise shock, or heart failure	ese, or come. List only	one cause on	caused each lir	the deat	h. Do not	enter the mo	de of dyin	ig, such a	s cardiac or	respiratory ari	rest,		Approximate Interval Between Onset and Death
		Physician		Immediate Cause (Final disease or condition resulting in death)	_	a. 54	577	ke									DAYS
	E	/Medical Examiner			- (	Due to	,	a conseq	uence of):								1000
	, A		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	ė J	b. Due to	4004		uence of):								
		and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	C. Duo to	/or 20	2 000000	uence of):								
	760,	be executed sicien and burial-transit	cal E	Total in deality East	- (	Due to	(OI as	a conseq	derice or).								
	289	ficate physics the t	edlc		_	_ d											
	Xo	eath certificate attending phys I for use as the	M/UE	IF FEMALE: 23b. Was decedent pregn		23c. If yes, ou		of pregna		3 □Ectopic i	pregnancy	,			23d.	Date of deliver	ery Day Year
	O. B	Attending Physicien: The law requires that the death certificate redeath. ector: After this certificate has been signed by the attending physby the funeral director, page 2 should be detached for use as the	by Physician/Medi	in the past 12 month: 1 ☐ Yes 2 2 No 9 ☐ Unknown	57	4⊟Preg 9⊟Unkn		time of c	leath	5 Other (s	pecify) _	<u></u>				Morari	buy tour
	ď	w requires that the di been signed by the should be detached	y Ph	Part II. Other significant of	onditions	contributing to d	death b	ut not res	ulting in th	e underlying	cause giv	en in Part	t I.	23e. Did to	bacco use	contribute to t	he cause of death?
	rds	equires en sign ould be	ed b											1 🗆 Y	es 2□N	lo 3 ☐ Prol	babły 4 Qunknown
	ecc	law re las be	Completed											24a. Was a autop	sv	4b. Were auto prior to co death?	opsy findings available empletion of cause of
	E B	: The				T -								1 ☐ Yes	med? 2 No	1 Yes	2 □ No
	V.	Physicien: The lay this certificate has al director, page 2	o Be	25. Was case referred to reaminer?  1 Yes 2 No	nedical	Hospital:	Inpatie	ent 2	ER/Outpa	tient 3 🗆 D	OA Oth	ar.		(Check only or ne 5 ☐ Resid		Other (Specia	M Mas Pico
	0	ding Phy h. After this funeral d	n: To	27. Manner of Death	D - 4'	28a. Date (Mor			28b. Tim	e of	28c. Injur	y at		8d. Describe h			<i>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</i>
	Sior	death. ctor: All y the fur	catlo	2 Accident	Pending investigation Could not be	n				М		Yes 2					
	Division of Vital Records, P.O. Box 68	after de Direct	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	determined	200. Flac	e of Inj ding, et	ury - At h c. <i>(Specii</i>	ome, farm, fy)	street, facto	ry, office		2	Bf. Location (S City or Tow		umber or Hun	al Route Number,
		To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	ical	29a. Certifier 1 C (Check only 2 M	ertifying Pl edicel Exa	hysician: To th miner: On the b	basis o	f examina	owledge, dation and/o	eath occurre r investigation	d at the tir	ne, date a	and place, a eath occurre	nd due to the o	ause(s) and date and pla	d manner as s	stated. o the cause(s)
		To the h within 24 To the F	Medical	29b. Signature and title of	certifier	and mar	nner sta	ated.		2:	c. Licens	e number	- r		29d. Date si	igned (Month,	Day, Year)
		F 2 2 3		Me	and	1				(	) 53	720	7	The same of the sa	Folory	sory 2	4 2004
				30. Name and address of	person who	completed cau	ise of c	teath (Iter	n 23a) (Ty	pe, Print)	. ( :	السر نا	-				300,
				31. Date filed (Month, Day		10 6000	Registr	ar's Sign	ature	x 00	17/2	3 re	m ?	1204			
		St Regist	ate trar			8 2004			. K	Lac	Sept of	12					

			. For	State of Maryland				Mental Hy	giene	
			1 - State Registrar		Cer	tificate of	Death		Reg. No. 20()	
	Physicia	an	Decedent's Name (First, Middle, Las					2. Date of De	Day Year	M
	/Medic	al	Josephine Louise N  4a. Facility Name (If not institution, give			4b. City. Town.	or Location of Deat	March 2	4c. County of De	4:40 A M
*	Examin		902D Blue Leaf Cou			Frederic			Frederic	k
	Funeral		5 Social Security Number 6. S	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs	(Month, Da	h v, Year) 9. B	irthplace (State or Foreign Country)
	Director		212-24-6823	75 The second se	Yrs.			July 3	, 1928 Ma	ryland
	and bw L		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary Ind	tor	Maryland Frederic	k Fred	erick					1 Yes 2 □ No
	or 288	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What (	Country?
	within 72 hours after death with the Maryland liene. I then Insturel', or Items 23s or 28s-f show the Medical Examination must be notified at		902D Blue Leaf Cou		0 140 1	21701	Historia Origina (6		USA	nerican Indian,
	item item	Funeral	11. Marital Status  1 □ Never Married 2 Narried	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 [X] No			Hispanic Origin? (S pan, Mexican, Puer	to Rican, etc.)	Black, Wh	
920	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:		Specify:	Mite
Maryland 21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occu	during most of wo	rking	16b. Kind of Busines	s/Industry
121	within then.	Idm	Elementary/Secondary (0-12)	College (1-4or 5+) 2	(0.5)	DO NOT use retire	<del>9</del> a)		plumbing/h	ostina
9	filed Hygi thar		17. Father's Name (First, Middle, Last)		bookke	eher	18. Mother's Na		Maiden Sumame)	leating
lan	d a b	To Be	Joseph Moudry				Ida Lou	ise Gosn	e11	
lary	and and sum		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Stree	t and Number or R	ural Route Numbe	er, City or Town, State	, Zip Code)
	s 1 and 2 f Health itsm 27 l		Orval S. Nelson, h			Blue Lea	af Court,	Frederi	.ck, Maryla	
Öre	tges 1 tof H : If its		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crer	natory or other pla				
Baltimore,	permit. Pages 1 Department of H Important: If Its any injury or ot		*4 □Donation 5 □ Other (Specification 21. Sign ture of Funeral Service Liquid	1212 1112			ery 3/5/		Frederick	Funeral Home
Ba	Depared Important in Succession		Kun M	Roscan MC	00999 1	06 East	Church S	treet. F	rederick.	
r	64.4		23a. Part1. Enter the disease, or com shock, or learn failure. List only	plications that caused the death	h. Do not ent	er the mode of dy	ing, such as cardía	c or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Acute myelo						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					
2	LAGIIIIICI	7.	Sequentially list conditions,	b. Due to (or as a conseq	uence of):					7
	uted d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that inflated events							
o,	te be executed ystcien and te burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	9 × 9	ilcal		d						
9 xo	leath certificate b attending physic I for use as the b	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	incv				23d. Date of d	delivery
Во	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 Live birth 2 Feta 4 Pregnant at time of d	I death 3	Ectopic pregnant Other (specify)	cy		Month	Day Year
o.	that the de ed by the detached	hysl	9 ☐ Unknown	9□ Unknown						
S, P	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	by P	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause g	iven in Part I.			to the cause of death?
Records,	w requir been si should l	ted								Probably 4 Unknown
lec	e law i	Completed						24a. Was auto	psy prior to death	autopsy findings available to completion of cause of ?
aiF	ician: The certificate rector, pag		as life and the discharge				OC Plans of Da	1 ☐ Yes	24 No 1 1 Y	es 2 No
Vital	ding Physician: The In. After this certificate ha funeral director, page	To Be	25. Was case referred to medical examiner?  1 Tyes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA		eath (Check only of the Home 5 X Resi	one) dence 6 □Other (S)	pecify)
Jo	ding Phys After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inj			how injury occurred	
ior	Attending r death. ector: Afle by the fune	atio	1 Natural 5 Pending 2 Accident investigation	n	,	M 1[	∵Yes 2 No			
Division	or Att	Certification;	3 Suicide 6 Could not be determined			reet, factory, office	9		Street and Number or wn, State)	Rural Route Number,
×	Hospitel (4 hours a Funerel D		29a. Certifier 1X Certifying P	nysician: To the best of my kno	owledge, deat	h occurred at the	time, date and plac	e, and due to the	cause(s) and manner	as stated.
\	To the Hospitel or Attencylin 24 hours after death To the Funerel Director: completely filled in by the	Medical	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my	opinion, death occ	urred at the time,	date and place, and d	lue to the cause(s)
	To th withir To th	Me	29b. Signature and title of celifier	11			nse number		29d. Date signed (Md	onth, Day, Year)
	6		118	(mm)			48184		2/3/6	7
	A		30. Name and address of purson who				act Frod	oriok M	D 21701	
	C+	ate	Elhamy D. Eskande	00 A 32 Registrar's Signa	nti do	0	eet, fled	elick, M	لا کا / UI	
	St Regist		marr v 6 2	UU4 REMENT	A. S. S.	18:14				

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		1	State of Maryland / Department of Health and Months   State of Waryland / Department of Health and Months   State of Windows   State of Waryland / Department of Health and Months   State of Waryland / Department of Health and Months   State of Waryland / Department of Health and Months   State of Waryland / Department of Health and Months   State of Maryland / Department of Health and Months   State of Maryland / Department of Health and Months   State of Maryland / Department of Health and Months   State of Maryland / Department of Health and Months   State of Maryland / Department of Health and Months   State of Maryland / Department of Health and Months   State of Maryland / Department of Health and Months   State of Maryland / Department of Health and Months   State of Maryland / Department of Health and Months   State of Maryland / Department of Health   State of Health   S	ental Hygier Reg. I	ne 2004 06955
	Physicia	ın	1. Decedent's Name (First, Middle, Last)  VWDY  OWEAL	2. Date of Death Month	Day Yeer 9:50 P M
	/Medic Examin	er	4e. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Bon Score Ho Sprtal  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Deeth  A  9. Birthplace (State or Foreign
1	Funeral Director		219-50-2306 1 M 2 F 58 Yrs. Months Days Hours Min.	Month, Day, Yea	45 Country)
	death with the Maryland ms 23e or 28e-f ehow round be notified at		10a. State 10b. County 10c. City, Town or Location  MD N/A Baltimore		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the 3e or 284	i Director	10e. Street and Number 10f. Zip Code 224 W. Wombard St ZNDFL 21223	10g.	Citizen of What Country?  USA
	72 hours after death "naturel", or Items 2:	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Marned 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No Specify: Yes, specify Cuban, Mexican, Puerto If Yes, Specify: Year or Dates:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: B/4
21215-0036	be filed within 72 hours after death with the Marylan Hygiene. Id eltygiene. Id other than "naturel; or Rems 23e or 28e-f show orth. The Markical Examination must be notified at	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)		. Kind of Business/Industry  Private
	should be filled within and Mental Hygiene. marked other than 'matic event, the Men	To Be Co	100	(First, Middle, Maid	
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura  Rosa Juhans / Jawihten  924 Wilsomburd St	I Route Number, Cit	ty or Town, State, Zip Code) Balfmane MD 21223
nore,	9 = 5		20a. Method of Disposition 1 ☐ Burial 2 DCremation 3 ☐ Removal from State	10.01	Location - City or Town, State
Baltimore,	permit. Pa Departmer Important: any injury sncs.		21. Signature of Jun (al Service Licen)  22. Name and Address of Facility France For TO 9 Tessien S	nenal S	emite e, PA & and 21201-1925
	最		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	or respiratory arrest,	Approximate Interval Between Onset and Death
1	Physician /Medical Examiner		disease or condition resulting in death)  Due to (or as a consequence of):		
196	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	AL C. L.	003 200
8760,	ate be executed obysician and the burial-transit	dicai Examiner	that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d. Human Immuno alliani	y old	ele
.O. Box 68	ath certific attending p for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2\overline{\text{No}}\text{o}   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9   Unknown   1   1   1   1   1   1   1   1   1		23d. Date of delivery Month Day Year
s, P	tuires that the de n signed by the a uld be detached		Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobace	co use contribute to the cause of death? 2 No 3 Probably 4 Donknown
i Record	The law require ate has been signage 2 should b	Completed by		24a. Was an autopsy performed 1 Yes 2 .	
Vital	Physicien: The this certificate ral director, pag	o Be	examiner?   Hespital:	me 5 Residence	e 6 ⊡Other (Specify)
on of	Attending Ph er death. ector: After th by the funeral	tion: T	27. Manner Death  1 Latural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 Accident investigation	28d. Describe how i	injury occurred
Division	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	and the state of t	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, Itate)
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical C	29a. Certifier  (Check only one)  1 Sertifying Physician. To the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the caus red at the time, date	e(s) and manner as stated, and place, and due to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier  29c. License number  29c. License number	29d.	Date signed (Month, Day, Year)
	2	Ī	30. Name and address of person who completed cause fide in (nem 23a) (Type, Print)  Vijayalakshmi Reddy Bon Secour Hospital Belto., MB	21222	)   KO 4-
_		ate	Vijayalakshmi Reddy Bon Secour Hospital Belto., MB  31. Date filed (Month, Day, Year)  32. Registrar's Signature	61663	

UNK 04-049		Black Indelible Ink. Ensure All Co	
04-01337	1- For Amend Item #27&28d per me G830 2 1- Registrar Unpend Item#23a,27,28a-f,Per M	od / Department of Health and Menta 413/04 tas we <i>departificates of Death</i>	Reg. No. 2004 06956
RPD	Decedent's Name (First, Middle, Last)	2. Dat	e of Death 3. time of Death
Physician /Medical	ANGEL MANUEL ORTIZ		bruary 20, 2004 0320 A M
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	1641 East Baltimore Street	Baltimore  [ast birthday] If Under 1 Year If Under 24 Hrs. 8. Date   8. Date	e of Birth  9. Birthplace (State or Foreign
Funeral Director	5. Social Security Number 6. Sex 1.⊠ M 2□ F 7. Age (In yrs. 56	Yrs. Months Days Hours Min. (Mo	e of Birth 9. Birthplace (State or Foreign Country)  25/47  PUERTO RICO
and and	Usual Residence of Decedent           10a. State         10b. County         10c. Ci	ity, Town or Location	10d. Inside City Limits
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  To marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Eventual than the notified at once.  To Be Completed by Funeral Director	MD N/A	BALTIMORE	1 ⊠Yes 2 □ No
vith the Mar t or 28a-f el ke neuther	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
h witt	226 S. HAVEN STREET	21224	USA
tter death v	11. Marital Status  12. Was Decedent Ever in U	J.S. 13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,	etc.) 14. Race - American Indian, Black, White, etc.
036 urs afte al', or it	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	¹⊠Yes 2□No Specify: PUERT(	O RICO Specify: WHITE
21215-0036 ad within 72 hours ati original. if than "natural, or than "natural, or than "natural, or than "natural."	15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
21215-00 ed within 72 holygiene. Per than "natura t, if a Medical Completed	(Specify only highest grade completed)	(Give kind of work done during most of working life. DO NOT use retired)	
212 3 with giene. rr than	Elementary/Secondary (0-12) College (1-4or 5+) Unknown O	CONSTRUCTION	CONSTRUCTION
nd he filed tall Hyg double otherwork.	17. Father's Name (First, Middle, Last)		Middle, Maiden Sumame)
/lar		NATIVIDA	
Maryland nd 2 should be file into and Mental Hy 77 lle and Mental Hy 77	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route	
and and maz7	MIGUEL ORTIZ	226 S. HAVEN ST. BALT] Place of Disposition (Name of Date	MURE, MD. 21224  20c. Location - City or Town, State
Ore Tof H or oth	Zoa. Wathou of Disposition	cometery, crematory or other place) CRED HEART CEME: 3/5/04	
Baltimore, bermit. Pages 1 a pepartment of Hea mportant: if item nny injury or othe 2006.	'4 Donation 5 Other (Specify)		
Bal Permii Impo	21. Signature of Funeral Service Licensee	KACZOROWSKI facije uneral 1201 DUNDALK AVE. B	
	23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	ath. Do not enter the mode of dying, such as cardiac or respi	ratory arrest, Approximate
			Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death)  Due to (or as a conse	ion and Thermal Injuries	
Examiner		45.05	
je sa sa sa sa sa sa sa sa sa sa sa sa sa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):	
executed executed in and inal-transit Examiner	Cause (Disease or injury that initiated events		
60, be exection and incident and burnal-to		equence of):	
376 ate be nysici he bu	d		
vision of Vital Records, P.O. Box 68760, Attending Physicien: The law requires that the death certificate be executed relath. ector: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transitification: To Be Completed by Physician/Medical Examin	IF FEMALE:		
30)	23b. Was decedent pregnant in the past 12 months?	tal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
O. E. ne dear the a hed for head for he	1   Yes 2   No 9   Unknown	death 5 Other (specify)	
P.O. that the de detached detached	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?
d by			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
i Records,  The law requires the cate has been signed page 2 should be completed by		24	4a. Was an 24b. Were autopsy findings available
I Rec			autopsy performed? prior to completion of cause of death?
Vital F Ician: Th certificate sector, pag		26. Place of Death (Che	2
of Vita hysician: his certific	examiner?	☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5	☐ Residence Other (Specify) ALSCURE
g Physical this seral of		28b. Time of 28c. Injury at 28d. D	escribe how injury occurred
ision ( Matending F death. ctor: After y the funer	1 Natural 5 Pending 2/20/04 real)	J.OI a M 1 Yes XXNo	in of Intentional House Fire
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the drs after death.  al Director: After this certificate has been signed by the drin the funeral director, page 2 should be detached or in by the funeral director, page 2 should be detached Certification; To Be Completed by Physic	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec	cifu) Ci	ocation (Street and Number or Rural Route Number, ity or Town, State)
Diving after all Dirich and Dirich all Diric	residence		E. Baltimore St., Baltimore, MD
D To the Hospital or within 24 hours at To the Funeral D completely filled if	29a. Certifier 1 Certifying Physicien: To the best of my kr	nowledge, death occurred at the time, date and place, and du nation and/or investigation, in my opinion, death occurred at t	
To the P within 24 To the F complete	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
S S S S S S S S S S S S S S S S S S S	250. Signature and made of german	O.C.M.E.	February 20,2004
	20 Non- and address of account who appropriated assume of death ///		
	30. Name and address of person who completed cause of death (Its	111 Penn Street, Baltimor	e, Maryland 21201
State	31. Date filed (Month, Day, Year) 32. Registrar's Sig	naturo A	
Registrar		sporked	

DHMH 17 Rev 1/2001

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			For State Registrar	State of Maryland		artment of tificate o			giene2 () (	) 4	06958
			Decedent's Name (First, Middle, Lace)	7				2. Date of Dea		Vans	3. Time of Death
	Physicia		THOMAS 1	RZYBYLA				MARCH	-	Year	11:55A M
)	/Medic Examin		4e. Fecility Name (If not institution, give	street and number)		4b Aty, Town	n, or Location of Dea		4c. Obunty o		
*	Exami	ŭ.	NORTH WEST (40	50, TALCEN	TER	Kand	ALLSTica	12	DAGI	con	ORE
	Funeral		5. Social Security Number 6. S			If Under 1 Ye Months Da		(Month, Day	v. Year)	Count	ece (State or Foreign
	Director		217 30 2031	X <sup>M 2□ F</sup> 62	Yrs.		,	July 1	7,1941	Mary	land
	pu 🔭		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10	d. Inside City Limits
	sho st	5	Maryland Baltimo:		tonsv:						1 □ Yes 2 □ No
	28a-f	Director	10e. Street and Number	00	- COHOV.	10f. Zip Cod	е		10g. Citizen of Wi	hat Count	ry?
	with					2122			United S	State	S
	na 23	Funeral	13 Benway Court	12. Was Decedent Ever in U.	S. 13. V	Was Decedent	of Hispanic Origin? (	Specify Yes or No-	14. Race	- America	ın Indian,
	r Itan	Fun	1 ☐ Never Married 2 🗓 Married	Armed Forces? 1 XYes 2 No	1	r Yes, specify C	uban, Mexican, Pue	rto Rican, etc.)	Віаск	, White, e	
33	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1959	-1963	1⊡Yes 2∏XI	No Specify:		Specify:	Whi	.се
Ò	filed within 72 hours after death with the Maryland Hygiene. other than "natural; or Itama 23s or 28s-f show ent, the Medical Examinat must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	fucation	(Give	dent's Usual Oc	ne during most of wo	orking	16b. Kind of Bus		ustry
21	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	tired)		Maryland		
2	ed wi ygien yer th	Col		2+	Dire	ctor of	Facilitie		State		ce
ng	d la b	Be	17. Father's Name (First, Middle, Last,					nme (First, Middle,			
₹	2 should be filed within 72 hours after death with the Marylan and Menial Hygiene.  Is marked other than "natural, or Itama 23s or 28s-f show aumatic event, the Medical Examiner must be notified at	ဥ	John Alfred Prz		-0. 11.		France eet and Number or F	es Helen			Code
Maryland 21215-0036			19a. Informant's Name/Relationship ( Mrs. Nicole K. H	<i>ro</i> blak-Daughtei	5806	ng Address (Str Artisa	n Drive;	Eldersbur	g, Mary	Land	21784
	1 and Health Am 27 ther t	1 2	20a. Mathod of Disposition					Date	20c. Location - C		
altimore,	Pages nent of h ant: If its ury or of	l	1 Burial 2 □ Cremation 3 □	Hemoval from State		sition (Name of matory or other		2.12.1			
Ē	rtmer rtant		* 4 □ Donation 5 □ Other (Specifical Service Liceration 21, Signature of Funeral Service Liceration 21, Signature of Funeral Service Liceration 3, 1997 (September 21), 1997 (Se				Park 03/09		-		Maryland
Ba	permit. Departi		21. Signature of Pulleral Service Lice	M00869	100		neral Hom			-	vland 2122
8760	Physician // Medical Examiner ithe pural-transit	dical Examiner	23a. Cart1. Enter the disease, or company to the art failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the death one cause on each line.  a. Due to (or as a consequence of the death one cause on each line.  Due to (or as a consequence of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause on each line.	vence of):	er the mode of	dying, such as cardia	cv/nR	SR AS	1	Ápproximate Interval Between Onset and Death
687	tificate ng phy: as the	edic	33.50	0.							
.O. Box	ne death cer the attendir hed for use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	∃Ectopic pregna ∃ Other (specify			23d. Date Mon		ry Day Year
S, D	signed by	y Pt	Part II. Other significant conditions	contributing to death but not resi	ulting in the u	nderlying cause	given in Part I.	23e. Did to	obacco use contri	bute to th	e cause of death?
rds	quire; n sign							1 🗆 1	res 2. Ino	3 🗀 Proba	abiy 4 Unknown
Vital Record	: The law requir cate has been si , page 2 should	Completed						24a. Was autop perfo 1 Tes	rmed? pr	/ere autoprior to coneath?	osy findings available inpletion of cause of
ita	Physician: Th this certificate ral director, pag	Bec	25. Was case referred to medical exampler?		/			eath (Check only o	ne)		
	di is	2	1 √Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☑	ER/Outpatie		Other: 4 Nursing	Home 5 Resid			)
n of	ng Pl		27. Man or of Death 1 √ atural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		njury at Work?	28d. Describe I	now injury occurre	ed	
Sio	Attending r death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be				1 ☐ Yes 2 ☐ No	0011			
Division	or Attending I after death. I Director: After d in by the funer	ertification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, sti	reet, factory, off	ice	City or Tox	Street and Numbe vn, State)	r or Hural	Houte Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C		nysician: To the best of my kno miner: On the basis of examina and manner stated.							
_	To the To the To the comp	Me	29b. Signature and title of certifier	•		29c. Lic	ense number		29d. Date signed		, ,
			(TYVin	0 1 6 weson	SILKE	9 1	11171		MARC	н5,	2004
	x 1.19		30. Name and Iddress of perform who	completed cause of death (Item	23a) (Type.	Print)		/	p :	- 1	0 10-5
_ \	3 1		E.P. Willia	750 NY 393	3 ST	JOHNS	LANE	ELL; CO	71(.19	1, M	2004 ARULAND 22,042
	St. Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	1	11 18	,			7-1-1

1	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2004 06950
Physician /Medical	1. Decedent's Name (First, Middle, Last)  Ceorge B. Parsons  2. Date of Death Month Day Year  03 02 04 0055 M
Examiner	As. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	213-22-9082 76 Yrs. Oct 7, 1927 Mary1and  Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
with the Ma	Salisbury   1   Yes X No
336 J36 JR, or Italian Struttle Struttle	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Security: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Fuerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Fuerto Rican, etc.)  16. Race - American Indian, Black, White, etc.  17. Yes 2 No Specify: White
	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  The condition of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)  maintenance worker  16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)  maintenance worker  electrical
Maryland 2121 d 2 should be filed within the and Mental Hygiene. To Is marked other then "traumatic event, the Mental traumatic event.	17. Father's Name (First, Middle, Last)  George T. Parsons  18. Mother's Name (First, Middle, Maiden Sumame)  Edna Pearl Townsed  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
- aga -	Ira Parsons/son  30510 Nutters Lane #36 Princess Anne, MD 21853  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Bate Commentery, Crematory or other place)
Balti Balti permit. Departri Importa any Inju	21. Sopeture of Europa Service Licence (12. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201
Physician /Medical Examiner	231. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.
'60, be execute sician and burial-trans	Cause (Disease or injury that initiated events resulting in death) Last  C. VEUMONIA  Due to (or as a consequence of):
1S, P.O. Box 687 res that the death certificate signed by the attending phys be detached for use as the by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
cords, P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Donknown
Vital Record Italan: The law requir certificate has been s rector, page 2 should	24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
on of Jing Phys After this funeral du	25. Was case referred to medical examiner?  1
Division To the Hospital or Attendent within 24 hours after death To the Funaral Diractor: completely filled in by the Medical Certificat	29a. Certifier (Check only   Check only   Ch
	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Micholand Thimman Agent IDO L. (20/0/1 St. Salisbury, MD 2/80/1  31. Date filed (Month, Day, Year)  MAR 0 8 2004

BRYANT M.PARKER 04-01621 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		Registrar  1. Decedent's Name (First, Middle, Last)	State of Maryland / 27,14R ME,0830,4730			2. Date of Death Month	Day Year	3. Time of Dea
Physicia		BRYANT M. PARKE	R		1	MARCH	4,2004	2;17P.
/Medic Examin		4a. Facility Name (If not institution, give : ST.JOSEPH HOSPITAL	street and number)	4b. City, Town, or TOWSON	r Location of Death		4c. County of Deat BALTIMORE	h
Funeral Director		5. Social Security Number 6. Sex 15 15	7. Age (In yrs. last bi	rthday) If Under 1 Year  Yrs. Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Y	(ear) 9. Birti Co 1957 MAR	nplace (State or Fo untry) YLAND
		Usual Residence of Decedent  10a. State 10b. County		vn or Location				10d. Inside City Li
liffed a	ctor		1/A	BALTIMOR	RE			1 💢 Yes 2
a or 26 Lbeng	Director	10e. Street and Number		10f. Zip Code	1207	10g	g. Citizen of What Co	untry?
ns 2;	Funeral	1413 INGLESIDE	12. Was Decedent Ever in U.S.	13. Was Decedent of H	l 207 lispanic Origin? (Spec	ify Yes or No-	14. Race - Ame	
"natural", or items 23a or 28a-f show ledical Extininer coust be notified at	by Fun	1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:	ican, etc.)	Black, White Specify:	BLACK
"natura	Completed	15. Decedent's Edu (Specify only highest grad		a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working	9 16	6b. Kind of Business/	Industry
stal Hygiene. od other than event, the Me	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	STEELE WOR		В	ETH STEE	LE
other ent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name			
= 0 ·	To B	OSCAR CARROLL			ELLEN PA			
t Health and Meritom 27 is marke		19a. Informant's Name/Relationship (Ty ELLEN CARROLL,		b. Mailing Address (Street 113 INGLES				
it of Health If item 27 or other tr		20a. Method of Disposition 1 □ 28urial 2 □ Cremation 3 □ F	cemete	of Disposition (Name of ery, crematory or other place	Da		oc. Location - City or	Town, State
rtmer rtant ijury		*4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	ARDU	JTUS MEMOR	ss of Facility HOW		ARYLAND	ME
impo any ir	0 3	Willie E 1	fowell 1	4600 LIBI	ERTY HGHT	S AVE,	BALTO.	
nysician Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused effe death. Do no cause on each line.  Dilated Cardiony  a.  Due to (or as a consequence	ppathy	ng, such as cardiac or	respiratory arres	t,	Approximate Interval Betwee Onset and Dea
caminer	Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury	Due to (or as a consequence	of):				
/sician and e burial-transit	cal Exar	resulting in death) Last	Due to (or as a consequence	9 of):				
by the attending physi tached for use as the I	Physician/Medi	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	l3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	h 3 Ectopic pregnancy 5 Other (specify)	,	-	23d. Date of del Month	ivery Day Yea
pe de	by	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause giv	ren in Part I.		cco use contribute to	the cause of dea
been s	eted					24a. Was an		topsy findings ava
ate has page 2	Completed					autopsy performe Yes 2	od? prior to death?	completion of caus
is certificate director, pag	o Be	25. Was case referred to medical examiner? 1X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 XER/C	Outpatient 3 DOA	26. Place of Death			
fter th	$\vdash$	27. Manner of Death 1X Natural 5 □ Pending		Time of 28c. Injury Wor	v at 2	Bd. Describe how	ce 6 Other (Specialized)	city)
i Diri	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)			Bf. Location (Stre City or Town,	et and Number or Ru State)	iral Route Numbe
within 24 hours a To the Funeral I completely filled	Medicai C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my knowledger: On the basis of examination a	ge, death occurred at the tinned or investigation, in my d	me, date and place, al opinion, death occurre	nd due to the cau d at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
within 2 To the complet	Med	29b. Signarure and title of certifier	and manner stated.	29c. Licens	se number	290	d. Date signed (Monta	n, Day, Year)
		) Sorki	(MU)		.M.E.	MA	RCH 5,200	4
		and the second second	ompleted cause of death (Item 23a	(Type, Print)				

			. For	State of Marylar	· ·		Mental Hy	giene	1 0000
		_	1 - State Registrar		Certifica	te of Death	2. Date of De	eg. tto:	3. Time of Death
	Physici /Medic		1. Decedent's Name (First, Middle, Las	RUTLA	EDGE	Town and assistant of Door	Month		900 YM
	Examin	er	4a. Facility Name (If not institution, give	F HEAL	-TH CARE	, Town, or Location of Deat	MORE	BALT	I MORE-CITY
	Funeral Director		194-10-1718	ex 7. Age (In yrs.	. last birthday) If Under	or 1 Year   If Under 24 Hrs   Days   Hours   Min.		rth (98 9.	Birthplece (State or Foreign Country)
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
	Ba-f sh	ctor	ND N/	A B	ALTIMOR			10g. Citizen of Wha	1 🗗 🗡 es 2 🗆 No
	3a or 2	Funeral Director	10e. Street and Number	FORD RD.	101. 2	21214		0.3	5.A:
	teme 2	uner	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 DNo	U.S. 13. Was Dec	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	specify Yes or No to Rican, etc.)	)- 14. Race - Black, '	American Indian, White, etc.
980	ral, or	5	1 Never Married 2 Marned 3 Widowed 4 Drivorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specity:		Specify:	WHITE
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-f show he Medical Exercities crass Le crofiffed at	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)	16a. Decedent's Us (Give kind of w life. DO NOT	ual Occupation rork done during most of wo use retired)	rking	16b. Kind of Busin	
212	filed with Hygiene. Ither ther	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	HOME	MAKER	(5 · 15 · 1)		HOME
land	ould be fill Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last)	NOWN			NKNO I	, Maiden Surname)	
Maryland	and and sm	-	19a. Informant's Name/Relationship (	Туре, Print)	Y	ss (Street and Number or R		er, City or Town, Sta	ate, Zip Code)
	s 1 and 3 f Heelth Item 27 other tr		DEPT. OF ACIN 20a. Method of Disposition	20b.	Place of Disposition (No cometery, crematory or		3891 6 J	20c. Location - Cit	
altimore,	Pege ment c ant: If ury or		1 Durial 2 Cremation 3 C 1 Donation 5 Other (Specify	(y)	toly TRIVI	TY CAY 3	604	BALTE	J. MD.
Balt	permit. Peg Depertment Important: I any injury o once.		21. Sign ture of the ral Service Aicer	Speck &	SKUR	Address of Eacility	2829 H BALT	WDSCN 5., MD.	ST. 21224
ı			23a. Part1. Enter the disease of com shock, or heart failure. List only Immediate Cause (Final	[/		ode of dying, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse	quence of):	time			
	Examiner	-	Sequentially list conditions,	b. Due to (or as a conse	entra				
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Deep	neatre	Joint I	) fear		
760,	sician and burial-transit	cal Ex	resulting in death) Last	Due to (or as a sise					
687	tificate ng phys as the		le seune	d	7		-		
O. Box	The law requires that tha death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tal death 3 Ectopic			23d. Date o Month	
s, P.O	ires that the signed by	ρ	Part II. Other significant conditions of		sulting in the underlying	cause given in Part I.			ute to the cause of death?
ord	w require	eted	19412926	mondish			24a. Was	24h Wo	Probably 4 Tunknown re autopsy findings available
Division of Vital Records,	sician: The law certificate has briector, page 2 s	Completed					auto	psy prio dea	th?
Vital	ysician: The ils certificate ha	Be	25. Was case referred to medical examiner?	Hospital:		Others	ath (Check only		
of	g Phys er this eral dir	n: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?		idence 6 Other ( how injury occurred	(Specify)
sion	tending leath. tor: Aft the fun	catlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	n	М	1 ☐ Yes 2 ☐ No	28f Location /	Street and Number	or Rural Route Number,
25. Was case referred to medical examiner?  1   Yes 2   No									
	Hospi 24 hour Funer stely (ill	Medical	29a. Certifier T Certifying Pt (Check only one)  2 Medical Examone)	nysician: To the best of my kr miner: On the basis of examir and manner stated.	nowledge, death occurre nation and/or investigation	d at the time, date and plac on, in my opinion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	er as stated. If due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	\	2	9c. License number		29d. Date signed (A	Month, Day, Year)
	n		Johnson		Type Print	D 314 14		2/25	,107
	9		30. Name and address of person who	ASIAMI 82	1 N . En	fano St fr	nte 30 d	Palt Balt	inne MD 21201
	Sta Regist		31. Date filed (Month, Day, Year)  MAR 1 8	32. Registrar's Sign	nature Anne	1)			Month, Day, Year)  SO Y  IMME MD 2120

		•	For State Registrar	State of Ma	rylan				ealth a Death	ind M			7111	) 4	06962
	Physici	an	Decedent's Name (First, Middle, Last     TYPENION		DOI:	ILES					2. Date of De Month	Da		/ear	3. Time of Death
	/Medic	al	VERNON EI  4a. Facility Name (If not institution, give	MER	KOW	ILES	4b. City,	Town, or	Location o		Feb. 22			Death	B:30pm
	Examir	er	Montgomery Villag		Care		Gai	ther	sburg			M	ontgo	mer	у
	Funeral Director		5. Social Security Number 6. Se 577-26-4021			last birthday) 3 Yrs.		r 1 Year	If Under a		8. Date of Bir (Month, Da 11/14	th ly, Year, 192	o v	Cour	
	the Maryland 28a-f ahow collified at	ector	Usual Residence of Decedent           10a. State         10b. County           MD         Montgome           10e. Street and Number	State 10b. County 10c. City, Town or Location Montgomery Rockville						10g. Ci	tizen of Wh	10d. Inside City Limits 1 X Yes 2 □ No			
	with t	급	4616 Harlan Stree	t				0853			ĺ				•
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or items 23a or 28a-f ahow other than "natural", or items 23a or 28a-f ahow event, the Medical Expaning return to untillied at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Xidowed 4 Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Black,							White,	White, etc.	
	e filed within 72 ho at Hygiene. I other than "natu vent, the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 5	DO NOT u	ork done o ise retired	e Cle	rk		Death Day Year   3. Time of   22, 2004   8:30pm   4c. County of Death   Montgomery   9. Birthplace (State of Country)   4/1920   Virginia   10d. Inside Cit   1½ Yes   10g. Citizen of What Country?   U.S.A.   10g. Citizen of What Country?   10g. Citizen of What Country?   10g. Citizen of What Country?   10g. Citizen of Country   10g. Citizen   10g. Citizen of Country   10g. Citizen of Country   10g. Citize						
yland	should be filed nd Mental Hygid marked other imatic event, II	To Be C	William Emory Rowles  Mary L. Patton												
Mar	12 sh n and 7 is m		19a. Informant's Name/Relationship (T) Robert Rowles, so												
e,	1 and Healtl em 2		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of			Date				
nor	eges ont of it: If it y or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ion Ce	~		0	2/27	/2004	Bur	tonsv	'i11	e, Maryland
Baltimore,	permit. Peges 1 and 2 should be Department of Health and Monta Important: If Item 27 is marked any injury or other traumatic a once.	d	2 Signature Funeral Service Licens		0133	/ 2	2. Name a	nd Addres							
3760,	death certificate be executed  When the discrete be executed to the entire of the certification and the certification and the purish that the certification and the certificatio	dical Examiner	23a. Part 1. Enter the disease, or compshock, or hear tailure. List only of shock, or hear tailure. List only of list of the case or condition resulting in death)  Sometimes of the conditions of the case. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last	ilications that caused in e cause on each line.  a. Acute M Due to (or as b. Diabete Due to (ur as Hyperte Due to (or as d. D	yoca a conseq s Me a conseq nsio	rdial quence of): 11itus quence of). n				cardiac	or respiratory a	rrest,			Interval Between Onset and Death
.O. Box 68		Physician/Med	230. Was decedent pregnant												
s, P	quires that n signed b uld be deta	b	Part II. Other significant conditions of	entributing to death b	ut not res	sulting in the u	nderlying	cause give	en in Part I.						
Il Record	. The law requires that the cate has been signed by the page 2 should be detache.	Completed									perfo	psy ormed?	pri	or to co ath?	ompletion of cause of
Vital	Physician: 1 this certifical ral director, p	o Be	25. Was case referred to medical examiner?  1 \sum Yes 2 \sum No	Hospital:		ER/Outpatie		OA Oth			n (Check only		€ □Othor	/Co.co	6.1
of		<b> -</b>	1 Yes 2 🛣 No  27. Manner of Death 1 🛣 Natural 5 🗆 Pending 2 🗀 Accident investigation	1  Inpatie 28a. Date of Inju (Month, Da		28b. Time of Injury		28c. Injun Worl							, , , , , , , , , , , , , , , , , , ,
Division	el or Attending s after death. il Director: After in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	ome, larm, st	reet, factor	ry, office						or Aun	al Route Number,		
	To the Hospitel c within 24 hours af To the Funerel D completely filled in	edical	29a. Certifier 1 X Certifying Ph (Check only 2 Medical Examone)	ysician: To the best iner: On the basis o and manner st	f examina	owledge, deal ation and/or in	vestigation	n, in my o	pinion, dea	d place, th occur	and due to the red at the time,	date an	d place, an	nd due t	o the cause(s)
	Tot Tot Com	Σ	29b. Signature and title of certifier	- ter				9c. Licens 04116					uary		2004
	54		30. Name and address of person who o	completed cause of completed cause of completed cause of completed cause of complete cause of completed cause of	octo	m 23a)(Type r's Dr	Print) . Gen	cmant	own,	MD 2	20874				
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAR 0 8 2004	32. Registr											

			For State Registrar	State	of Maryla	-	artmer e <i>rtifica</i> :					giene Reg. No. 2	nnL	06963		
ĕ	القريسة	10	Decedent's Name (First, Middentification)	le, Last)			71111041				2. Date of De	4 10	Year	3. Time of Death		
	Physicia /Medic	_	ABRAHAM RHIN	EHART							March		1004	528P M		
	Examin		4a. Facility Name (If not institution	^	1 11	adal	4b. City	Town, o	r Location	-		4c. Co	unty of Death			
1	Funeral		5. Social Security Number	Genera 6. Sex	7. Age (In y	rs. last birthda		r 1 Year		r 24 Hrs.	8. Date of Bir	th Year)	N/Z 9. Birth	plece (State or Foreign		
garage.	Funeral Director		250-24-8911	1 M 2	77	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 08-05	-1926	SC	intry)		
	and w		Usual Residence of Decedent  10a. State 10b. Count	у	10c.	City, Town or	Location							10d. Inside City Limits		
	the Maryland 28a-f show	tor	MD	N/A		BALT	IMORI	C						1.∏Yes 2□No		
_	death with the ime 23a or 28a r inium be could	by Funeral Director	10e. Street and Number				10f. Zi	p Code				10g. Citizer	of What Cou	intry?		
L.	ath will	rai	2716 AUCHENT	ORY TER				212				US	A Race - Amer Black, White			
120	after dea or Itame	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	Armed	Decedent Ever in d Forces? es 2 ☐ No	1 U.S. 13	If Yes, spe	ident of H scify Cuba	an, Mexica	rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.)	14.	Black, White	, etc.		
ද <b>ශී</b>	ral', or Ita		3 Widowed 4 Divorce	lf-29ses	, Give or Dates:		1 🗆 Yes	<b>¾</b> No	Specify	<i>'</i> :		Sp	Specify: BLACK			
Abrahan 21215-0036	72 hc natur	Completed	15. Decede (Specify only high	nt's Education est grade complet	ed)	(Gi	edent's Usi ve kind of w	ork done	during mo	st of work	ring	16b. Kind	of Business/I	ndustry		
7 5	within ene. then	omp	Elementary/Secondary (0-12)	Collec	ge (1-4or 5+)		ERCH <i>I</i>			ION		MART	TIME			
	2 should be filed within 72 hours and Mental Hygiene. Is marked other then "natural", reumatic event, "In Medical Era	Be C	17. Father's Name (First, Middle	, Last)							e (First, Middle					
ylar	Menta Menta arked	To E	JERIAMAH RHI	NEHART							GOSTO					
Rhinehart Baltimore, Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 is marked other then "natural", or Itame 23e or 28e-f sho other treumatic event, its Medical Exercises into the recitied at		19a. Informant's Name/Relation EMMA LEE RHI				-				al Route Numb ERR。B					
e, 6	tem 27		20a. Method of Disposition			b. Place of Dis	position (Na	me of			Date		ion - City or 1			
) - E	Pages ent of nt: If It		1 Donation 5 ☐ Other		rom State	SARRIS	ON FO	RES	Ť	03-	12-04	MAR	YLAND	)		
2 alti	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is eny injury or other tre 900.		21. Signature of Fune al Service	e Licenso	1000	1	22. Name a			11/	OWELL					
	g Q E ≥ 9		Mulle	CHOU	ulle						HTS AV		LTO.	MD 21207 Approximate		
			23a. Part1. Enter the disease, shock, or heart failure. Listingued in the control of the control	st only one cause	on each line.	-			ng, such a	s cardiac	or respiratory a	11651,		Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)		SDIFATO to (or as a con		ailu	re								
	Examiner		Sequentially list conditions,	Se Se	DSiS											
	pe is	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	***	of (or as a con											
	xecute and al-tran	Examiner	that initiated events resulting in death) Last		e to (or as a con			700-	¥				-			
760	icate be executed physician and s the burial-transit	ical E		o En	d Stad	ge Re	nal	D	1 Sec	rse	ر					
Box 68760	certificat inding phy use as th	P	IF FEMALE:			)										
Box	eath certif attending for use as	lan/	23b. Was decedent pregnant in the past 12 months?	100	, outcome of pre ive birth 2 ☐F regnant at time	etal death	Ectopic		у			230	<ol> <li>Date of deliment</li> <li>Month</li> </ol>	very Day Year		
P.O.	the de y the a ched f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		regnant at time Inknown	or death :	5 ☐ Other (s	респу)								
	Attending Physicien: The law requires that the death certifical releath.  ector: Atler this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as it	by Ph	Part II. Other significent condi	tions contributing	to death but not	resulting in the	underlying	cause giv	ven in Part	1.	23e. Did	tobacco use	contribute to	the cause of death?		
g	v require been sig should b	ted t									10	Yes 2 ☐ N	No 3□Pro	bably 4 @Unknown		
Seco	e law r has be je 2 sh	Completed									24a. Was	psy pmed?	24b. Were aut prior to death?	topsy findings available ompletion of cause of		
<u>=</u>	icien: The l certificate ha rector, page										1 ☐ Yes	2 DNO	1 Yes	2□ No		
Vit	ystcler is certif directo	To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐ No	Hospital:	1 Inpatient	2 🗌 ER/Outpat	ient 3 🗆 🛭	OA Ott	205		th <i>(Check only one</i> 5 Resi		Other (Spec	ify)		
٥ ر	ding Physicien: h. Alter this certific tuneral director.		27. Manner of Death	/	ate of Injury Month, Day Yea	28b. Time	of	28c. Injui			28d. Describe			,		
sion	ttendin death. stor: All	catic		stigation			М	1 🗆	Yes 2	□No	00/ 1			10 1 11 11		
Division of Vital Records,	i di di	Certification:	4 Homicide dete	mined 20th	Place of Injury - A building, etc. (Sp	At home, farm, ecify)	street, facto	ry, office			City or To		vumber or Hu	ral Route Number,		
A-	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by			ring Physician: T												
	the Ho hin 24 I the Fu npletely	Medical	one)		he basis of exam manner stated.	nination and/or					rred at the time,					
	To 1 To 1	2	29b. Signature and title of certif	A	at	>	2	Sc. Licens	se number	2		29d. Date s	signed (Month	, vey, rear)		
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		1	For State Registrar	State of	Marylan		artmer <i>rtificat</i>			and M	ental Hy	giene. Reg. No.		\$	069	64
			Decedent's Name (First, Middle, La	st)							2. Date of Dea		Yea	1	3. Time of	
	Physici /Medio		Lachone B. Kludlek											L:35	РМ м	
	Examin		4a. Fecility Name (If not institution, given Joseph Richey			Town, or Ltimo	Location o	of Death		4c.	4c. County of Death					
	Funeral Director		5. Social Security Number 6. S 214-76-1200	Sex 7. I□M 2⊠F	Age (In yrs. 46	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Dec 6,	1957	9. I	Gountry Country ary I	e (State or and	Foreign
	p ,		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y. Town or Lo	cation							10d	. Inside Cit	y Limits
	aryla shov	2	MD											1X Yes	2 🗆 No	
i	28a-f	Director	10e. Street and Number				10f. Zig	Code				10g. Citi	zen of What	Country	1?	
3	Mith Se or	2	2670 Kennedy Ave	enue #102				2121	18				USA			
Ī	18 23 18 23	Funeral	11. Marital Status	12. Was Deced	ent Ever in U	.S. 13.	Was Dece			gin? (Spe	ecify Yes or No	-	14. Race - American Indian, Black, White, etc.			
326	be filed within 72 hours atter deeth with the Maryland Hygiene. d other than "natural" or items 23e or 28e-f show event, the Madical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	If Yes, Give	1 TYes 2 7 No			Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:					Specify: black			
21215-0036	2 ho	ted	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usu	al Occupa	ation during mos	t of worki	ng	16b. Kind of Business/Industry				
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aZ	2 shou and N is mai		19a. Informant's Name/Relationship	Type, Print)		19b. Maili	ng Addres	S (Street a	and Numbe	er or Rura	l Route Numbe	er, City o	r Town, State	e, Zip Co	ode)	
	and 2 salth n 27 i		Richard Lovelace	/friend		26	70_Ke	nned	у Аус	nue	#102 Ba	ltin	ore,	MD —	21218	}
Baltimore,	Department of Health 2 Stooms Department of Health and Meninportent: If item 27 is marks any injury or other traumatic socs.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [ 1 ☐ Donation 5 ☒ Other (Special Content of the content		ate	Place of Dispo cemetery, crea			е)		Date	20c. Lo	cation - City	OF IOWI	i, State	
Bait	permit. Page Department Important: If any injury or		21. Signature of Funeral Service Lice ROTALO	Dade, D	irecto:	r S	<sup>2 Name a</sup> tate altim	Anato Ore,	omy B	oard 2120	655 W.	Bal	timor	e St	reet	
	Physician / Medical Examiner partial itausit is private in private	cal Examiner	23a. Pan 1. Enter the disease, or conshock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (o	used the deat ch line.	Givt juence of): jww juence of):					ukoen Y dromu		halo	l ir	pproximate the value of the val	ween Death
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  9 Unknown							23d. Date of delivery Month Day Year			rear ,		
ds, P.	signed by	b	Part II. Other significant conditions	contributing to dea	ith but not res	sulting in the u	inderlying	cause give	en in Part I	l.	23e. Did t		se contribut		cause of d	
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Vital	Physician: r this certificantal director,	Be	25. Was case referred to medical examiner?	Hospital:				Oth	0.0		h (Check only o				41-20	0000
	Physi this c	2	1 Yes 217 No 27. Manner of Death	1 □ In 28a. Date of		ER/Outpatie		UA	4 🗆 141	ursing Ho	me 5 Resident		Other (Sourced	specify)	FTUS	Ince
n n	Jing A	lon	1 (DNatural 5 ☐ Pending	(Month	, Day Year)	Injury	м	28c. Injun Worl 1 □	k? Yes 2□	No		,	•			
	l or Attending after death. Director: Afte I in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not determine	28e, Place of	of Injury - At h g, etc. (Special	ome, farm, st	reet, facto	y, office		28f. Location (Street and Number or Rural Route N City or Town, State)				Route Num	ber,	
_	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	edical Co	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	hysician: To the laminer: On the barand manner	sis of examina	owledge, dea ation and/or in	th occurre nvestigatio	d at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) date and	and manne place, and	as stated	ed. ne cause(s	.)
	o the	Med	29b. Signature and title of certifier	^ . I .	1		29	c. Licens	e number			29d. Dai	te signed (M	onth, Da	y, Year)	
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			30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type	Print)	St			time.	ve.	Mi	) 2	128	7
	St. Regist	ate	31. Date filed (Month, Day, Year)		gistrar's Sign	ature	1	Fr. 94	1 5							

FEBRUARY 22, 2004

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2004 9:12a M Koran ocoske MARCH /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** FUTURECARE-CANTON HARBOR BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 6/1/35 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F 212-32-5178 68 MARYLAND Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Exaction rount be notified at 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7144 EASTBROOK AVE. or Herns 23a 21224 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 [X] Yes 2 ] No If Yes, Give Year or Dates: 1958-60 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Importent: If tem 27 is marked other then "natural", or ther eny injury or other traumatic event, the Mudical Exercises 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 0 SHIPPING CLERK MOBAY/BAYER/PEMCO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK ROMANOWSKI VERONICA PEPLOUSKA ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7144 EASTBROOK AVE. BALTIMORE. MRS. SHARON ROMANOWSKI MD. 21224 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State HOLY ROSARY CEME. 3/4/04 DUNDALK, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipensee KACZUROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 21222 23a. Part1. Enter the disease, or corr plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Immediate Cause (Final sastroin testinal **Physician** Bleed Menedicate disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** nte vices 2 DSIES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown has been Polorower Bestrockens 24b. Were autopsy findings available prior to completion of cause of death? Jonie 24a. Was an page 2 autopsy performed? for illaction Atrial certificate 2 X No 1 Yes 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 A Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number D19667 uncel CHIMAN .. 03-04-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 411 Crris Hereny BUNNIE 24061 GLOW MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 8 2004 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 L Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Schaffner 2004 12:29 AM Richard March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Baltimore 7. Age (In yrs. last birthday) Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic event, the Medical Examinat must be rutilised an once. 1XYes 2 □ No by Funeral Director TIMORE 10g. Citizen of What Country? 21206 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES SELF 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 11 COB BUNDY ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO IEW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location City or Town, State 1 Bunal 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) 21. Signature on Funeral Service Licensee 23a. Part1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Propulse (or as a consequence of): Preumonitis **Physician** hours /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificete has 20 No 22 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☑ Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No completely filled in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and titte of certifier 29c. License number 29d. Date signed (Month, Day, Year) P17647 3 Stoycheff
31. Date 12-2 completed cause of death (Item 23a) (Type, Print) 22 S. Greene St. Baltimore, MD Greene 31. Date filed (Month, Day, Year) 32. Registrar's Şignature State Registrar

			For State Registrar	State of Marylar	nd / Departme	nt of Health and	Mental Hygien		06967			
	Physicia	an	Decedent's Name (First, Middle, Lass		neered		2. Date of Death Month Day Year 20 10 35 p					
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		y, Town, or Location of Dea	th 4	c. County of Deat	h			
	Funeral Director		5. Social Security Number 6. Se	X 7. Age (In yrs.	last birthday) If Und Month:	er 1 Year If Under 24 Hr s Days Hours Mir		9. Birt Co	hplace (State or Fereign unity)			
	Maryland	tor	10a. State 10b. County	City 10c. Ci	ty, Town or Location	ti mare			10d. Inside City Limits			
	death with the Maryland ma 23a or 28a-f ehow r mast be notified at	rai Direc	10e. Street and Number	TOSE AVE		21212		itizen of What Co	-			
_	after or its	by Funeral Director	11. Marital Status  Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		edent of Hispanic Origin? ( pecify Cuban, Mexican, Pue 2D/No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White Specify:				
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altimore,			20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Specify	Removal from State	Place of Disposition (No cemetery, crematory of	other place)	B. 2 2004 B	Location - City or	Town, State			
Ball	Departition Departition of the permit of the		21. Signature of Funeral Service Licens	Sporder)	h. SKA	ADA Falto	BAITE-	150N 5 HD 21	カスナ			
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	Examiner	ner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying		104 EARS							
,09/	ate be executed hysician and he burial-transit	cai Examin										
Box 687	death certificate e attending phys d for use as the		IF FEMALE: 23b. Was decedent pregnant	d23c. If yes, outcome of pregn.				23d. Date of deli	ivery			
P.O. Bo	res that the death signed by the atte I be detached for	Physiclan/Med	in the past 12 months? 1 □ Yes 2 0 No 9 □ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown				Month	Day Year			
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ai Rec	ician: The law certificate has b rector, page 2 st	Completed					24a. Was an autopsy performed?	prior to d	topsy findings available completion of cause of 2 No			
Vital	nding Physician: 'th.' : After this certifica stuneral director, p	Be c	25. Was case referred to medical examiner?	Hospital:	TER/Outpatient 3 ☐ I	Other	eath (Check only one)	2 COtto (C	4.1			
ot	Phy r this	): To	15 Yes 2 □ No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?	Home 5 Residence		ciry)			
Division of	dea ctor y the	Certification:	1 ▼Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28f. Location (Street a	ınd Number or Ru	ral Route Number,						
ā	To the Hospitet or At within 24 hours after of To the Funeral Direct completely filled in by	edical Cer	29a. Certifier 1 Certifying Ph	building, etc. (Speci /sician: To the best of my kni iner: On the basis of examina and manner stated.	owledge, death occurre		e, and due to the cause(	s) and manner as				
,	To the within 2 To the comple	Med	29b. Signature and title of certifier	The N	2	9c. License number	29d. D	ate signed (Monti	n. Day, Year)			
	\		30. Name and address of person who	completed cause of death (Itel	m 23a) (Type, Print)	ampertan Hosp	TOGLOCH RA	1 1	LEVARA WAZYLAND 2123			
A.	Sta Registr		31. Date filed (Month, Day, Year)	32. Register's Sign		ik o		(				

		-	1 - State Amend Item #20	State of Maryland Da-c per fh G8	d / Depa 329 <b>3</b> 48	rtment	of Health	and Me	ental Hyg	jiene leg. No.	2004	06	968		
	Physicia /Medic	_	1. Decedent's Name (First, Middle, Last) JOHN HENRY						2. Date of Dea Month	th	Year	3. Time of 人: 31	Death PM		
	Examin Funeral	er	4a. Facility Name (If not institution, give some solution) Special Security Number 6. Sec. 216-40-0064	lly Hospit	ast birthday) Yrs.		Town, or Location timore 1 Year   If Und Days   Hours	der 24 Hrs. s Min.	8. Date of Birth (Month, Day	Year)	Coun	•	or Foreign		
	Director		Usual Residence of Decedent  10a. State 10b. County		, Town or Lo	cation		(	ct.10 1	1941	Mary	0d. Inside Ci			
	with the Mary a or 28a-f sh be notified	Director										1 Yes	2   No		
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	ithin 72 hour ne. nen "neturel" Medical Ex	Completed to	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation s completed) College (1-4or 5+)	(Give life. l	kind of wor DO NOT us	l Occupation k done during m e retired)	nost of workin	g		bb. Kind of Business/Industry				
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altimore,	permit. Pages Department of I Importent: If it eny injury or o		1 Burial 2 Cremation 3 □P 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	G1€		en Mer	morial I		_	-Gle	n Burnio	, Md.			
8	Physician	23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or bear failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. Effdural abscess											te tween Death		
8760,	Medical  hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									y yrs	r		
P.O. Box 68	death certifi e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Ectopic pro				3d. Date of delive	· ·						
	luires that the n signed by th uld be detache	þ	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying c	ause given in Pa	urt I.		tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Anknown					
Reco	The law requires ate has been sign page 2 should be	Completed							24a. Whas a autop perfor 1 ☐ Yes	SV	death?	osy findings npletion of c	available ause of		
Division of Vital Records,	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	To Be	27. Manner of Death 1√2Natural 5 ☐ Pending	Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury			Nursing Hon	(Check only or ne 5 Resid 8d. Describe h	ence 6	□Other (Specify occurred	r)			
Division	s after death. If Director: After al Director: After al in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	8f. Location (S City or Tow	îtreet and n, State)	Number or Rura	l Route Num	ber,							
	To the Hospital within 24 hours of To the Funeral completely filled	edical	(Check only 2 Medical Exemi	sician: To the best of my kno iner: On the basis of examina and manner stated.	tion and/or in	vestigation,	in my opinion, o	death occurre	ed at the time, o	date and	place, and due to	the cause(s			
•	To To COU	×	29b. Signature and title of certifier  Audit	G MID	23a) /T·	Priot)	D 3	49	74	Ma	ich 6	04			
	<i>5</i>	ate	30. Name and address of person who could be address. The state of the	completed cause of death (Item  F(TA, M), 6  2004 32. Referrar's Signs	100 (1908) 100 (1908) 100 (1908)	with a	charle	es stra	eet, Bo	2111	more, 1	1D21	230		
	Regist	rar	MATTIN O O	1											

DHMH 17 Rev 1/2001

Schweler, John H.

		•	For State Registrar	State of N	Marylan			nt of H <i>te of L</i>		ınd M		giene Reg. No.2	004	06969
P	hysicia	an	1. Decedent's Name (First, Middle, L				- <del>-</del>				2. Date of Dea Month	Day	Year	3. Time of Death
1	/Medic	al	4a. Facility Name (If not institution, o	STAGGERS	ar)		4b Cib	Town or	Location o	f Death	MARC		Zoo	1 /2
	Examin	er	LEVINDALE NURSING AN					BALTIM					NA	
Fu	uneral			Sex 7.		last birthday)		er 1 Year	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day	h /. Year)		olece (State or Foreign
	rector		195-38-3862	1 □ M 2 💢 F		76 Yrs.	I VIOTATI	Days	Hours		NOV. 21,	1927		MD
pue	*	-	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
Aarylä	r show	6												1 XYes 2 □ No
the h	28e-	Director	MD NA  10e. Street and Number			BALTI	1	ip Code				10g. Citizen o	f What Cou	ntry?
with	3a or		5403 WILLOWMERE	WAY				21	212				USA	
deet	ms 2	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.	S. 13.	Was Dec	edent of Hi	spanic Orio	gin? (Spe	ecify Yes or No- Rican, etc.)	14. R	ace - Americ	
<b>21215-0036</b> of within 72 hours after deeth with the Maryland rigiene.	item 27 is marked other then "natural", or items 23s or 28e-f shov other traumatic event, the Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced		No			2 X No	Specify:	, 1 00110	riodii, oto.,	Spec	ify: AFR	ICAN RTCAN
5-0 72 ho	lical	Completed	15. Decedent's (Specify only highest of			16a. Dece	dent's Us	ual Occupa	ation luring most	of worki	na	16b. Kind of		The Street
27 ig 9	- Wes	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT	use retired	)					
d 21 filed w Hygier	T E		10th	00			DOM	ESTIC	10 Matha	ela blama	(First, Middle,	Administra Commis	HOM	ES
be fill	even	Be	17. Father's Name (First, Middle, La	St)					18. MOTHE				ame)	
aryla should ind Men	is marked other then sumatic event, Ita Ms	ဥ	FRANK SIMPKINS  19a. Informant's Name/Relationship	(Tuna Print)		10b Maili	na Addra	es (Stroot s	and Numbe		LLAIN RU I Route Numbe		m State Zir	Codel
Maryland d 2 should be file th and Mental Hy	7 Is r traur					1						21212	ii, Siaie, Zip	0000
Baltimore, No sermit. Pages 1 and Department of Health	If item 27 I or other tre		HANNAH JOHNSTON (DA  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3	UGHTER)  □Removal from Sta		5403 Place of Disponentery, cre-	sition (N	ame of		-	MORE, MD	20c. Location	n - City or To	own, State
Pages ment of	lant:	1	* 4 □ Donation 5 □ Other (Spec	cify)		ZION C			-	/9/04		LANSDOWN	VE, MD	
Baltim permit. Pag Department	Important; If is any injury or once.		21. Signature of Funeral Service Lic	ensee		2:	2. Name	and Addres	s of Facilit	y WY	LIE FUNER	AL HOME	PA	
- au	= 4 G		23a, Part 1. Enter the disease, or co shock, or heart failure. List on		and the deet	Do not on	638	N. GI	LMOR S	TREET	BALTIMO	RE, MD	21217	Approximate
/M	sician and the private transit the private transit tra	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	as a conseq						leros			
9	as	ledlo												
. Be	ed by the attending p detached for use as:	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outco 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ∐ Feta tat time of d	Ideath 3[	⊒Ectopic ⊒ Other (	pregnancy specify)					Date of deliver Month	ery Day Year
Vital Records, P.O sicien: The law requires that the	speen signed the should be dete		Part II. Other significant conditions	contributing to deat	h but not res	ulting in the u	ınderlying	cause give	en in Part I.		23e. Did to	Δ		he cause of death?
ecol law rec	shou	Completed									24a. Was		. Were auto	opsy findings available
Re la	ate has page 2	E									autop perfor	med?	prior to co death? 1 \( \sum \text{Yes}	mpletion of cause of
ta en:		0	25. Was case referred to medical						26. Place	of Death	(Check only o		1 2 103	
of Vita Physicien:	w 5	To B	examiner? 1 ☐ Yes 2 ◯ So	Hospital: 1 hp	atient 2	ER/Outpatie	nt 3 🗆 [	Othe	9r: 4 ☐ Nu	rsing Ho	me 5 ☐ Resid	lence 6 🗆 O	ther (Specil	(y)
0 5	96		27. Manner of Death 1	28a. Date of I (Month,	njury Day Year)	28b. Time o	of	28c. Injury Work	at		28d. Describe h	ow injury occ	urred	
Division of lor Attending Phy after death.	octor: Al	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 390 Place of			M reet, facto	10	Yes 2⊡i				mber or Rura	al Route Number,
Division or hours after	To the Funeral Director: completely filled in by the	Cert									City or Tow			
Hosp 24 hou	Fune etely fi	edical		Physician: To the be aminar: On the basi and manner	s of examina									
To the	To th	Me	29b. Signature and title of certifier	1			2	9c. License	e number			29d. Date sigr	ned (Month,	Day, Year)
) [ ]	/		Whalldo-	Sheam	2	- 1	2	02	37	57	7	Masc	h 4.	2004
	h		30. Name and address of person wh	o completed cause	of death (Iter	п 23а) (Туре	Print)		0		1 /	1	0	01
	9		Debra / West.	leines	10	24	34	6	Ber	Nec	lese H	ve 1	In b	to, 14212
	Sta Regist		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	ature 2	loan	61						

			For State Registrar	State o	f Marylan	d / Depa	artment rtificate	of H	ealth a	and M	ental Hy	giene Reg. No.	2004	069	970
ė,	División.	3	1. Decedent's Name (First, Mid	dle, Last)							2. Date of De. Month	ath Day	Year	3. Time of D	Death
	Physici /Media		Doris	Ма	rie		Sobot	ta			March	6	2004	1255	М
7	Examir		4a. Facility Name (If not instituti						Location of	f Death		4c. C	ounty of Death		
300		, 3	Anne Arundel					apo]		24 Hrs	0.0		e Arun		-
- 5	Funeral		5. Social Security Number 217-74-9531	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. ) 85	iast birthday) Yrs.	If Under 1 Months	Days	If Under: Hours	Min.	8. Date of Bird (Month, Da Sept.	n <i>y, Year)</i> 25 10	9. Birth Cot	place (State or intry)	Foreign
-	Director		Usual Residence of Decedent								sept.	23,13	10 111	gland	
	yland		10a. State 10b. Coun	у	10c. City	y, Town or Lo	cation							10d. Inside City	/ Limits
	Mar.	tor	MD Anne	Arunde1	Mi	llersv	rille							1 🗆 Yes	XX No
	or 28	Director	10e. Street and Number				10f. Zip (	Code				10g. Citize	on of What Cou	intry?	
	death with the Maryland rms 23a or 28e-1 show rrsust be recitive at		1704 Baldwin	Drive				2110	)8			U	SA		
Maryland 21215-0036	within 72 hours after dea ene. then "naturel", or Items the Macical Examination	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☒ Widowed 4 □ Divorce	Armed Fo	2 <b>⊠</b> No ∕e		Was Decede If Yes, specr 1 ☐ Yes 2		spanic Orig n, Mexican Specity:	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)		Race - Amer Black, White pecify:		
ဍ	2 hou	ted	15. Decede	ent's Education		16a. Dece	dent's Usual	Оссира	tion			16b. Kind	of Business/l	ndustry	
212	be filed within 72 ho tal Hygiene. d other then "netu event, I.te Moulcal	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed)  College (1	I-4or 5+)	(Give life.	kind of work DO NOT use	retired,	<i>uring</i> most )	of workir	ng				
7	od with	No.	12	05035 (		Homen	aker					0w	n Home		
D	be filed ital Hygie of other event, II	Be (	17. Father's Name (First, Middle	a, Last)					18. Mothe	r's Name	(First, Middle,	Maiden Si	umame)		
<u>X</u>	should be ind Mental s marked c umetic eve	2	Unknown	Invern							Connor				
ā	2 she and is m	0 0	19a. Informant's Name/Relation		1		•				Route Numbe				
	es 1 and 2 should b of Health and Ment fitem 27 is marked r other treumetic e	l s	Patricia A. F	rice (Daug		1254 lace of Dispo			Road,		wnsvil				
Baltimore,	Pagement ant: It ant: It o		20a. Method of Disposition	(Specify)	State	emetery, crer Lady	of the	herplace e Fi	elds	3/11	/2004		ttion - City or T ersvil		
ä	permit. Depart Import eny inj		21. Signature of Funeral Service	e Ligencee			Name and Harde:	sty	Funer	cal E	lome, P	.A.	1 - LL 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		
	40300		10 0.	Ann			12 K1	dge1	y Ave	enue,	Annap	olis,	MD 214	+OI Approximate	
}	Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	a	Verm (or as a consequence	ania	-		, 5001 05					Interval Between Onset and De	een
N. N.	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a consequ	uence of):									
,097	ite be executed ysician and ne burial-transit	cal	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):								-	
O. Box 68	The law requires that the death certificate tie has been signed by the attending phy: oage 2 should be detached for use as the	Completed by Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live b	tcome of pregna pirth 2 Tetal lant at time of di lown	death 3	Ectopic pre					230	d. Date of deliv		ear
S,	res that igned by be deta	oy Ph	Part II. Other significant condi	tions contributing to de	eath but not resi	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of de	ath?
ğ	w require been sig should b	ted	Dehydrati	7							101	′es 2 🗆	No 3 ☐ Pro	babiy 4 ⊠Un	iknown
Vital Records,	(0 (4	Comple		al Failu	12						24a. Was autop perfo 1 Yes	rmed?	24b. Were aut prior to co death? 1  Yes	opsy findings av ompletion of cau 2 No	/ailable use of
<b>\frac{1}{2}</b>	sicier certif rector	Be c	25. Was case referred to medic examiner?	Uponital		ED/6		Othe			(Check only o	1.1.	7-		-
	Phys rthis ral dir	1.	1 Yes 21 No 27. Mann Death	28a. Date	npatient 2  of Injury	ER/Outpatier 28b. Time of	-	c. Injury	4 🗆 Nu		ne 5 🗆 Resid			fy)	
U <sub>O</sub>	ding F h. After funer	ti O	1 Natural 5 ☐ Pend	/4400	th, Day Year)	Injury	M	Work			00. 00301001	iow injury c	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Division of	Atten er deat ector: by the	Certification:	3 Suicide 6 □ Coul	not be 28e. Place	of Injury - At ho ng, etc. (Specif	ome, farm, str					Bf. Location (S City or Tox	Street and I m, State)	Number or Rur	al Route Numbe	ar,
_	To the Hospitel or within 24 hours after To the Funerel Dirtompletely filled in	edical C	29a. Certifier 1 Certify (Check only one) 1 Medic	ing Physician: To the I Examiner: On the b and man	best of my kno asis of examina ner stated.	wledge, death tion and/or in	occurred a vestigation, i	t the tim in my op	e, date and inion, deat	d place, a	nd due to the old at the time,	cause(s) ar date and pl	nd manner as s lace, and due t	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certs	ior			29c.	License	number			29d. Date :	signed (Month,	Day, Year)	
7	. 0/		M.			2	D	505	829	7		3/6	104		
	13		30. Name and address of person			<u> </u>	el M	edic	of a	zube	Anna	phis	MO	21401	
4.8	Sta Regist		31. Date filed (Month, Day, Yea		egistrar's Signa		1 0								
DH	MH 17 Rev 1/2	\$	MAR (	8 2004	Exerce	"/	borte			·					
						ORIGIN	AL								

ysician		Registrar ecedent's Name (First, Mic Frances M.					rtificate	J. 5001		2. Date of Dea Month Februar	Day		
/ledical aminer		acility Name (If not institut			oer)		4b. City. To	wn, or Location		rebruar	1	200 County of D	
annine.		Stella Mar	_		,			imoniu				,	timore
eral ctor	2	13-26-2780	6. Sex		Age (In yrs. 77	last birthday) Yrs.	If Under 1 Months (	rear If Und	der 24 Hrs. s Min.	8. Date of Birtl (Month, Day Jan 17	19:		Birthplace (State or Fore Country) Maryland
tified at	10a.	State 10b. Cour MD Anne	Aru	ndel	10c. Cit	y, Town or Lo Pas	adena	100.100					10d. Inside City Lim
iner sust be natified	10e. 2	Street and Number 116 Lake Dri	ve				10f. Zip C	21122	2			zen of What	Country?
P o		Marital Status □ Never Married 2□ M B□ Widowed 4 ሺ Divorc	arried	12. Was Deced Armed Forc 1 Tes 2 If Yes, Give Year or Date	es? <b>K</b> ]No		Was Deceder If Yes, specify			cify Yes or No- Rican, etc.)	1	14. Race - A	merican Indian, /hite, etc. White
t, the Medical I	E	15. Deced (Specify only high ementary/Secondary (0-12	nest grade		or 5+)	(Give	dent's Usual ( kind of work DO NOT use	done during m retired)			16b. Kir	nd of Busine	ess/Industry
Con				0		C	civil s	ervice	worke	r	1	U.S. A	Army
To Be	17. [	Father's Name (First, Midd Benjamin Ko		ejski						(First, Middle, Klewci		,	
Emag T	19a	. Informant's Name/Relatio				19b. Mailir	ng Address (S	treet and Nur	nber or Rural	Route Number	r, City or	Town, Stat	e, Zip Code)
y or other tre	20a.	Method of Disposition 1 ☐ Burial 2 ☐ Crematio 4 ፟ Donation 5 ☐ Other	n 3 □R	<del>_</del>	20b. P	122 G Place of Dispo	sition (Name	of		keysvi]			21030 or Town, State
any injur		Si alur Juneral Sirving Roma d		ade Vi	rector	St Ba	Name and A ate Ar altimor	Address of Fa	Board 21201	655 W.	Bal	timore	e Street
an cal ner	lmn dise rest	Patt. Enter the disease, shock, or heart failure. Linediate Cause (Final lass or condition litting in death)  uentially list conditions, y, leading to immediate se. Enter Underlying se (Disease or injury	or compile ist only on	. INANT Due to (or	n lin <i>e</i> .	uence of):	er the mode o	f dying, such	as cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
dical Examiner	resu	se. Enter Underlying se (Disease or injury initiated events ilting in death) Last		Due to (or	as a conseq	uence of):							
Physician/Medical	IF F 23b	EMALE: Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23		n 2 ☐ Feta it at time of d	Ideath 3	Ectopic pregi Other <i>(speci</i>				2:	3d. Date of Month	delivery Day Year
ed by P	Fait	II. Other significant cond	tions con	tributing to dea	th but not res	ulting in the ur	nderlying caus	e given in Pa	rt I.				o to the cause of death?  Probably 4XIUnknow
ral director, page 2 should be detached for use:  To Be Completed by Physician/A										24a. Was a autops perform	ned?	death	autopsy findings availab to completion of cause o ? 'es 2 \sum No
o Be		Was case referred to medi examiner? I □ Yes <b>X</b> No		ospital:		ED/O				(Check only on		-	
funeral d		Manner of Death  XNatural 5 □ Pen	ding stigation	1 ☐ Inp 28a. Date of (Month,		ER/Outpatien 28b. Time of Injury		Injury at Work?	20	e 5∐Reside 3d. Oescribe ho	ence 6 ow injury	Other (S)	pecify) HOSPICE
Medical Certification:		3 ☐ Suicide 6 ☐ Cou	_	28e. Place of building	Injury - At ho , etc. (Specif	ome, farm, str				Bf. Location (St City or Town	reet and n. State)	Number or	Rural Route Number,
edical C		Certifier (Check only one) Certifi	ring Phys	ician: To the base and manne		wledge, death tion and/or inv	occurred at the occurred of the occurred at th	he time, date my opinion, d	and place, ar eath occurred	nd due to the ca	ause(s) a ate and p	and manner place, and d	as stated. fue to the cause(s)
		Signature and title of certi	lier	)				cense numbe	-	2	9d. Date	signed (Mo	onth, Day, Year)
Com			- /						-				
N		Name and address of person				1 23a) (Type.	Print)						

2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:55 AM SARRIN 2004 SAMUEL March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Ot Baltimore botigaoti innit City N/A If Under 1 Year | 31 Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth Month Day, Year JAN. 10, I Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 213-01-2473 86 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23s or 28a-1 show any injury or other traumatic event, the Madical Examines must be notified at 1 ¥Yes 2 ☐ No N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6503 PARK HEIGHTS AVENUE #4-A 21215 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (1) Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER RESTAURANT 17. Father's Name (First Middle Last) Sapperstein 18. Mother's Name (First, Middle, Maiden Sumame) Be SAPPERSTEINanna 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ~2121519a. Informant's Name/Relationship (Type, Print) ANN H. SARRIN - WIFE 6503 PARK HEIGHTS AVENUE #4-1 BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON CHIZUK AMUNO 3/5/2004 BALTIMORE, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Juneral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myocardial 3 hours **Physician** Acuta /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical as the use 23c. Il yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed bluods Prumonia 2 🗹 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? Acute renai forthere page 2 s autopsy performed 1 Yes 2 No certificate 1 Yes 2 No ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To in by the funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled within 24 hours To the Funeral 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number - MD RUS-000 March 4, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Javillo, MD Sinai Hospital of 2 Baltimore 31. Date filed (Month, Day, War) 32. Registrar ignature State Registrar

**ORIGINAL** 

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

06972

Amend Item #17 per in 6829 3760 ff tag of Death Red. No.

			1 - State Registrar	State of Ma	ryland / Depa Ce	artment of I rtificate of			eg. No. 200	4 0697:
The state of the s	Physici /Medic		Decedent's Name (First, Middle, Last  MARVIN		SMITH			2. Date of Deat Month	Day Year	3. Time of Death 530 AM
是 他是 1	Examir Funeral	A	4a. Facility Name (If not institution, give SOHALS HUPLING BAY) 5. Social Security Number 6. Security Number 11	IEW MEDICA x 7. Age	(In yrs. last birthday)	_		8. Date of Birth		rthplace (State or Foreign ountry)
1	Director		225-48-0242  Usual Residence of Decedent  10a. State 10b. County	₹N 5 1 0	10c. City, Town or Lo	ocation		9/23/19	934  Vir	ginia  10d. Inside City Limits
	the Mary 28a-f sh	rector	MD Baltimo	re	Middle	River		1	0g. Citizen of What C	1 Tes 2 No
	3a or	Ö	3834 Clark Point	Road		213	220		U.S.A.	
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21215-0036	vithin 72 h ne. hen "netu e Wedical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	DO NOT use retire	during most of wor	king	16b. Kind of Business	lndustry
	filed v Hygie other t	Be Co	8 17. Father's Name (First, Middle, Last)		Disa	abled	18. Mother's Nan	ne (First, Middle, M	None Maiden Sumame)	
/lan	Vental	To B	Samuael J. Smith				Betty	Moubray		
e, Maryland	1 and 2 should should had Mallth and Mallth and Mallth and Mallth and Mallth are traumati		Janet Krystofiak/ 20a. Method of Disposition			Clark Po		Middle F	City or Town, State,  River, Mar  20c. Location - City or	yland 21220
altimore,	ages ant of h it: If ite y or o		1 ★ Burial 2 □ Cremation 3 □:  1 ★ Donation 5 □ Other (Specify)		cemetery, cre	matory or other pla of Faith	.	1	Baltimore,	
Baltir	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Sign ture of Funeral Service Licens		2:	2. Name and Addr	ess of Facility Mi	ller-Dipp		1 Home Inc.
S. 100 S. 100 S.	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. ARRYTI Due to (or as a	tMIA consequence of):			or respiratory arre	est,	Approximate Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CHRUNIC	consequence of):			DISEASE	<b></b>	MONTHS
.O. Box 6	death certifi e attending id for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	Fetal death 3	Ectopic pregnanc	су		23d. Date of de Month	viivery Day Year
ds, P	es be	by	Part II. Dther significant conditions co	ntributing to death bu	t not resulting in the u	nderlying cause g	iven in Part I.		pacco use contribute t es 2□No 3	o the cause of death?
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Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0.	ther	th (Check only on		
of	Attending Phys r death. actor: After this by the funeral dir	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day	28b. Time o	f 28c. Inju	4   Nursing h		once 6 □Other (Spe ow injury occurred	ecify)
Division	a Briga	Certification:	3 Suicide 6 Could not be determined	building, etc.				City or Town		
	the Hospital of the Hospital of the Funeral Dipletely filled in	Medical	(Check only 2 Medical Exam	vsician: To the best of iner: On the basis of and manner state	examination and/or in	vestigation, in my	opinion, death occu	rred at the time, da	ause(s) and manner a ate and place, and du	e to the cause(s)
		Σ	29b. Signature and title of certifier	road	ND	_	1961		9d. Date signed (Mon MARCH 4	
	ng St	ate	30. Name and address of person who of SANET RECURD, M  31. Date filed (Month, Day, Year)  MRD 0.8 2004	ompleted cause of de D 4940 32. Registra	PASTEYU A	VENUE	BALTIMO	ME MA	MARCH 4 MYLAND	21224

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 06974

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			1. Decedent's Neme (First, Middle,	Last)			2. Dete of Deet Month		3. Time of Death
4	Physicia /Medic		Catherine	B. Taylor	-		3	i (74)	405 AM
	Examin		4e Fecility Neme (If not institution,	give street end number)	^	4b. City, Town, or L	ocation of Death	4c. County of Dee	th
			6055. WI	ckham Road		Balt	more	N/A	
	Funeral			Sex 7. Age (In yrs. A	est birthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign
п	Director		231-22-2779	10 M 20 F 8	3 Yrs. Working Days	Tiodis Iviai.	4 23	20	VA
	p ,		Usual Residence of Decedent	40- 00-	. T				
	anyler show		10a. State 10b. County	1 Toc. City	, Town or Location				10d. Inside City Limits 1 2 7es 2 □ No
	Me Ma	용	MD	1/A	Baltimore				
	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Director	10e. Street end Number		10f. Zip Code		10	og. Citizen of Whet Co	
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	ter dea	Funeral	11. Marital Status	12. Was Decedent Ever in U,5 Armed Forces?	<ol> <li>13. Was Decedent of I If Yes, specify Cub</li> </ol>	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
20	9 9 E	Ę.	1 Neyer Married 2 Marrie	If Yes, Give	1□ Yes 2☑No				black.
21215-0020	72 hours efter natural', or ite dicel Exemine	d b	3 ☐Widowed 4 ☐ Divorced	Year or Dates:					
5	nath	Completed	15. Decedent's (Specify only highest)	Education grade completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of work	ing	16b. Kind of Business	Industry
12	withir ene.	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	CUST O	A		R. 11 (	A J. S. L. J.
	e filed v el Hygie other t vent, th	ပ္ပ	7 LT		C 0 37 0	18. Mother's Nam	- /First Stindella S	Daver. C	ounty Schools
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Ë	Pag ment ant: I	- 1	4 ☐ Donation 5 ☐ Other (Spe	city) Ba	Himone North	mal Cem.	3/5/04 _	Baltimon	e, MD
Baltimore,	Depertment of mportant: If any injury or once.		21. Signature of Funeral Service Li	ensee	22. Name and Addre	ess of Fecility	Fune	ral Ser	vice, P.A. Le MOZIZOI
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	4		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the death	. Do not enter me mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		0.000, 0.000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					Onset and Death
	/Medical		Immediate Cause (Final disease or condition	Iner	an ema				11.0
	Examiner		resulting in death)	Due to (or	as a consequence of):				790
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	icete be executed physician end s the buriel-transit	Eal	Sequentially list conditions,	Due to (or	as a consequence of):				
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of Vital	ian: ertific ctor,	Be	25. Was case referred to medical examiner?			26. Place of Deat	h (Check only one	<del>)</del>	
>	Physician: this certific	၉	1   Yes (25€ No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3□ DOA Oth	ner: 4 🗆 Nursing Ho	me Reside	nce 6 Other (Spe	cify)
2	ng PI		27. Manner of Death Natural 5 ☐ Pending	28e. Date of Injury (Month, Dey Year)	28b. Time of 28c. Injury Wor	ry et rk?	28d. Describe ho	w injury occurred	
.0	Attending or death.  ector: After by the fune	ta l	2 ☐ Accident investigat		M 1 🗆	Yes 2□No			
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could no determine		me, farm, street, factory, office		28f. Location (Str City or Town,	eet and Number or Ri State)	ıral Route Number,
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	To the Hospital or Attending Physician: The law within 24 hours efter death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Med	one)	and manner stated.					
	7 ¥it 500		29b. Signature end title of certifier		29c. Licens	e number	29	d. Date signed (Monti	n, Day, Yeer)
	2		1/1/		1) 2	1044		3/5/04	
			30. Name and address of person wh	o completed cause of deeth (Item	23a) (Type, Print)		- ~	10-	2122)
	(A) E		MI 165 thm	7000 - Ros	17 Happin	noly/C	My R	of BA2	Do MD
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	Registra	11							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 - 06975Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey Yeer Month **Physician** 02 VanKirk Sr. 4b. City, Town, or Location of Death MARCH 2004 3:47 a /Medical Robert 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner St. Mary's Hospital
5. Social Security Number 6. Sex Leonardtown Mary's Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 6. Sex 1 X M 2 ☐ F Days Hours 218-46-7370 56 5,1947 Maryland AprilUsual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 No Yes 2 No Directo N/A Baltimore <u>Maryland</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A.

14. Race - American Indian,
Bleck, White, etc. 21230 2242 Sidney Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 N/A Truck Driver Plumbing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be F. ည Sophia Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2045 Deering Ave. Baltimore, Maryland 21230 <u>Letha A. VanKirk (Wife)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a Method of Disposition 1X Burial 2 Cremation 3 Removal from State Maryland Veterans Cemt.03/05/04 Crownsville, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. 237 East Patapsco Ave Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final war tachycarda ventric afewhour disease or condition resulting in death) myocardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Destalia Completed by La. lure Anem 1a Coaculopathin 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Calure, espiration 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an 05 urosepsis discuse potension 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed P.O. Box 68760, VANKIRK Records, ROBERT Vital of

burial-transit and the attending physician as the use been has certificate this After

**Funeral** 

Director

ral, or Items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic avent.

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0036

with the Maryland

ō signed by the a Attending Physician: Division death. the Director in by t within 24 hours after To the Funeral Dire filled completely the l

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

Medical

4 Thomicide

m.D

2 Medicef Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

to the cause(s) and manner as stated.

D 00 51738

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAE AUNG PO BX 37 HOLLYWOOD MD

29b. Signature and title of certifier

MAR 0 8 2004

32. Registrar Signature

Goods?

			For State Registrar	State of Ma	aryland / De <sub>l</sub> <i>Ce</i>	partment of leartificate of	Health and Death		iene 00 L;	06976
	Physici		Decedent's Name (First, Middle, La THOMAS J. VALL					2. Date of Deat Month	th Day Year	3. Time of Death 5 50 A M
8	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)	imore	4b. City, Town, Baltiv	or Location of Deat		4c. County of Deat	
	Funeral Director		5. Social Security Number 6. S	Sex 7. Agi IXIM 2☐ F	e (In yrs. last birthda 73 Yrs.	y) If Under 1 Year Months Days			Year) Co	hplace (State or Foreign untry) NSYLVANTA
	Maryland	tor	10a. State 10b. County  MD BALTIN	ORE	10c. City, Town or	Location ARKVILLE				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	h with the	Funeral Director	10e. Street and Number 8311 OAKLEIGH RO	AD		10f. Zip Code 21234	}	1	0g. Citizen of What Co USA	untry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, itam 27 is marked other than "natural", or items 23s or 28e-1 show other traumatic event. The Medical Examiner must be notified at	by	11. Marital Status  1 ☐ Never Married 2▼ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:		3. Was Decedent of ff Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify:	
1215-0	within 72 ho ane. than "natur	Completed	15. Decedent's E (Specify only highest gr		(Gi life	cedent's Usual Occu ve kind of work done . DO NOT use retire	during most of wo	rking	16b. Kind of Business/	
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other than aumatic evant, the Ma	To Be Co	8TH GRADE  17. Father's Name (First, Middle, Last  ANTHONY J. VALI		1 11	LE & MARE	18. Mother's Nai	me (First, Middle, M		ON
e, Mary	1 and 2 should I Health and Meni tam 27 Is marker other traumatic		19a. Informant's Name/Relationship ( DELPHTNA M. VALI 20a. Method of Disposition		JGHTER 8	iling Address (Stree  11 OAKLE]  position (Name of		BALTIMOR	City or Town, State, 2 RE MD 212	34
Baltimore,	permit, Pages 1 and Department of Health Importent: If item 27 any injury or other t		1 Deposition 1 Disposition 1 Deposition 2 □ Cremation 3 □ Cremation 3 □ Other (Special Service Lice 21. Signature of Deposition 1 Depo	(y)	cemetery, c	rematory or other pla CEMETERY  22. Name and Addr	3/1	2/2004	BALTIMORE,	MD
Ba	Deptition of the control of the cont		23a. Part1. Enter the disease, or com		I the death. Do not e	8521 LOCH	RAVEN B	LVD. TOW	ISON, MD 2	HOME, P.A. 1286 Approximate
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Seps	a consequence of):					Interval Between Onset and Death
\$4.	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase or in July that initiated events	b. Due to (or as	a consequence of):	· · · · · ·				7.
8760,	cate be executed obysician and the burial-transit	dicai Exa	resulting in death) Last	Due to (or as	a consequence of):					
P.O. Box 6	The law requires that the death certifics ate has been signed by the attending ploage 2 should be detached for use as I	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	B Ectopic pregnand 5 Other (specify)	y		23d. Date of deli Month	very Day Year
Ś	w requires that s been signed b should be deta	d by Pi	Part 11. Dither significant conditions	Contributing to death b	ut not resulting in the	underlying cause gi	ven in Part I.		pacco use contribute to es 2 □ No 3 □ Pro	
l Reco	The law recate has bee page 2 sho	Complete	Cornney heart à	uscase, Ch	rouse this	tention lung		24a. Was ar autops perform 1 🗆 Yes 2	24b. Were au prior to death?	topsy findings available completion of cause of
Vita	Physician: r this certificated free ral director,	Be	25. Was case referred to medical examiner?	Hospital:		C		ath (Check only one	θ)	
Division of Vital Record	To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	atlon: To	1 Yes 2 No  27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		of 28c. Inju			once 6 □Other (Spec ow injury occurred	cify)
Divis	To the Hospital or Attending within 24 hours after death.  To the Funaral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injuding, etc	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Str City or Town	reet and Number or Ru n, State)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Exa	nysician: To the best miner: On the basis of and manner sta	f examination and/or	investigation, in my	opinion, death occu	urred at the time, da	ause(s) and manner as ate and place, and due	to the cause(s)
	To with	2	29b. Signature and till of certifier	100 -		RES	se number		NACCH 7	2004
	15			Keller	Sina		19/04	Baltin	wre	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar' Signature	4 6 4	- /6			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Stata
RegistracAMEND ITEM #19a PER INF G829 3/16/06 Intificate of Death Rag. No. 2 0 1 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Sinai Seltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. Jast birthday) **Funeral** 260-01 1 □ M 202 F Months d Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Exactings must be notified at Baltimore NIA 1 Yes 2 □ No Be Completed by Funeral Director mD 10g. Citizen of What Country? 10e. Street and Number 0/201 330L USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 Yes 2 No Specify: Black Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

FACTORY WORKER 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) actor permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: If itam 27 ia markad other tt any injury or other traumatic evant, the once. 18. Mother's Name (First, Middle, Maiden, Symame) 17. Father's Name (First, Middle, Last) -ucias Holder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PABETATIRLY NOTINGON TO TO THERE Balto. MD Vauqnn 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 Removal from State MD National Mem.PR. 3 \* 4 □ Donation / 5 □ Other (Specify) 21. Signature 21229 hilton Pass BACTO, mu 23a. Part. Englithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Immediate Cause (Final disease of ondition resulting in death) Physician rechnos /Medical Due to (or as a consequence of): Examiner ceredo uscula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 2 X No 1 TYes 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) WAR 0 8 2004

Decir

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HI WEST Belvedere 32. Registrar's Signature

md 21215

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** ee /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Olung Wara If Under 24 Hrs If Under 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days 1**∑** M 2□ F Months Hours 38 Director 574-92-0680 01/23/1966 Iran Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours aftar death with the Marylend nent of Heatth end Mental Hygiane. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiane. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director MD Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6334 Cedar Lane 21044 17an 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Never Married 2☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Ali Jon Vahdatshoar Qhodsieh Nadi 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Faramarz Vahdatshoar/cousin 2852 Rolling Fork Way, Glenwood, Md. 21738 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Depertment of Important: If It any Injury or o 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete LOrraine ParkCemetery 03/04/04 Baltimore, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Witzke Funeral Homes, Inc. . Signature of Funeral Service License 5555 Twin Knolls Road, Columbia, Md. 21045 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of): Physician/Medical Examiner neumoni Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that tha death certificate be Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? After this certificate has 200 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ER/Outpetient 3□ DOA within 24 hours eftar death.

To the Funeral Director: After this completely filled in by tha funeral is 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) Medicai Certification: 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 🗌 Yes 2 🗆 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ţ, 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eted ceuse of deeth (Item 23e) (Type, Print) 69VS 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Mar	yland / Depa		Health and	Mental Hy	Reg. No.	4 06979
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last VILBUR 14. Facility Name (If not institution, given 14. OWARS COUP	ACH street and number)	λ.		or Location of Deat	2. Date of Dea Month MANCH	Day Yea  S Z C O  4c. County of D	eath ,
	Funeral Director		5. Social Security Number 6. S		In yrs. last birthday)		ar If Under 24 Hrs	(Month, Da	h y, Year) 9. I	Birthplace (State or Foreign Country) aryland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "netural; or Items 23s or 28a-1 show any houry or other traumatic event, Ite Madical Examiner must be notified at an	Funeral Director	10a. State 10b. County MD Howard 10e. Street and Number 4481 Ten Oaks F	l Co.	Oc. City, Town or Lo Dayton	10f. Zip Code			10g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 No Country?
-0036	hours after deal	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed	12. Was Decedent Eve Armed Forces? 1 Tyes 2 No If Yes, Give 1 9 Year or Dates.	58-60	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ N	f Hispanic Origin? (Suban, Mexican, Puer o Specify:			hite
Maryland 21215-0036	rould be filed within 72 d Mental Hygiene. narked other than "ne natic event, It e Medic	Be Completed	(Specify only highest gra  Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last)  Michael Vlach	College (1-4or 5+)	(Give	kind of work don DO NOT use retii	e Engine  18. Mother's Nai	eer me (First, Middle,		Co. Govt.
	s 1 and 2 should of Health and Men Item 27 is marke other traumatic	P	19a. Informant's Name/Relationship (1) Mrs. Bernadine 20a. Method of Disposition	Vlach		Ten Oa	aks Road	urai Route Numbe	or, City or Town, State  n, MD 21  20c. Location - City	036
Baltimore,	permit. Pages Department of I Importent: If Its any injury or of		1 Se Burial 2 Cremation 3 C 4 Donation 5 Other (Specify 21. Signature of Fyneral Service Lican	)	Sacred	Heart ( 2. Name and Add	of Jesus	Ceme.		, MD ral Home, P e, MD 21222
	Physician /Medical Examine prujet in pricial interpretation and provide int	Examiner	23a. Part1. Enter the disease, or comy shock, or heart failure. List only limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ISCHEW (  Due to (or as a c	onsequence of):  ARY ARTER onsequence of):	MYOJAT	нү	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
O. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed it hours after death. Funeral Director: After this certificate has been signed by the attending physician and lety filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal death 3	Ectopic pregnan	ісу		23d. Date of o	delivery Day Year
ords, P.O.	w requires that t been signed by should be deta	ρ	Part II. Other significant conditions of					23e. Did to		to the cause of death?  Probably 4 Onknown
al Reco	n: The law re licate has be rr, page 2 sho	Completed		INSUFFIC	IENCY				sy prior t med? death 2A No 1 □ Y	
Division of Vital Records,	nding Physician: The lath. ath. rr: After this certificate ha	atlon: To Be	27. Manper of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time of	28c. Inj	ther: 4 \substitute Nursing H		ne) ence 6 □Other (S) ow injury occurred	pecify)
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	building, etc. (	Specify)			City or Tow		
<	To the Hos within 24 ho To the Func completely f	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examone)  29b. Signature and titlers septifier	ysicien: To the best of n iner: On the basis of ex and manner stated	amination and/or inv	vestigation, in my	opinion, death occu	rred at the time, o	ause(s) and manner late and place, and d 29d. Date signed (Mo	ue to the cause(s)
	/		30. Name and address of person who	completed cause of death	h (Item 23a) (Type,		8296		MARCH	
	Sta Registr		JOSEPH F. GIB  31. Date filed (Month, Day, Year)  MAR 0 8 2004	BONS MD	Signature	ANNA!	LOUS RD, 8	LLICOTT	City, MD	21042

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1600 2004 February 705 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BAL IMERE UNION MEMORIAL 7. Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Months Hours Days N.C 237-26-3548 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County rai', or items 23e or 28a-f show Examiner must be notified at Yes 2 No EASTPOINT Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number MIHPOINT 2122 BLUD Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Dres 2 No Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify: HITE 3 ☐ Widowed 4 Delvorced WWI "natural", f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) EMPEIED 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KNOWK 100 ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BATTIMORE 1000 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
any injury or oti 1 Burial 2 Cremation 3 Removal from State SYILLE 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of). Examiner The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of) the attending physicien P.O. Box 68760 Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown After this certificate has been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ blnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 4 No 24a Was an 1 ☐ Yes 2 No Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 ☐ Yes 12 No 1 Varipatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 27. Manner of Dea h 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funerel Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie February 050293 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin moria coperman s Signature 31. Date filed (Month, Day, Year) 32. Registra State MAR 0 8 2004 Registrar

Stephen H. Wallace 04-01610 RJ

> Phys /Me Exar

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any highry or other traumatic event, the Medical Exerting manual barnatified at

Pnysicia /Medica Examine

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State o	f Ma	ryland / Department of Health	and Mental Hygiene?	nni.
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	1 - For State Registrar Unper	d Item#	State of 23a,27,Pe	of Mar	yland G829,	/ Dep 3/1 <b>2</b> /	artmei <b>M</b> ilijoa	nt of ⊢ <i>te of i</i>	lealth <i>Death</i>	and M	lental Hy	gien Reg. N		04	069	81
	1. Decedent's Name (Fi	rst, Middle, L	ast)								2. Date of De				3. Time of Di	eath
cian	Stephe	en	Н.	V	Valla	ice					Month March 3.		ay 1	Year	1050 p	М
dical siner	4e. Facility Name (If not		ive street and nu				4b. City	, Town, or	r Location		MOLCII J.		c. County	of Deat	1258 P.	
miei	North Arunde			,			G1	en B	urnie	2			Anne A			
,	5. Social Security Numb	T	Sex	7. Age (	(In yrs. las	st birthday)		er 1 Year	If Under		8. Date of Bi	rth			hplace (State or F	Foreign
r	220-84-1973	3	1 M 2□F	3	34	Yrs.	Months	Days	Hours	Min.	(Month, D. Nov.09	ау, Yea 196	r) 19	Co	vland	
	Usual Residence of Dec	edent							1		101.05	170		11011	yranu	
	10a. State 10t	o. County		1	IOc. City,	Town or L	ocation								10d. Inside City	Limits
ō	Md. Ai	nne Ar	undel Co	o.	G1	en Bi	ırnie	2							1 ☐ Yes 2	No
Director	10e. Street and Number					<del></del>	10f. Z	ip Code				10g. C	itizen of	What Co	untry?	
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era	11. Marital Status		12. Was Dec	edent Ev	er in U.S.	13	Was Dece			rigin? (Spe	ecify Yes or N	0-			rican Indian.	
Ë	1 Never Married	2□ Married	Armed F	orces? 2 ⊠ No			If Yes, sp	ecity Cuba	an, Mexica	n, Puerto	Rican, etc.)			ck, White		
ρ	3 ☐ Widowed 4 📉	_	If Yes, G	ive 11			1 🗌 Yes	2 No	Specify.	:			Specif	whi	te	
b		Decedent's				16a. Dece	dent's Us	ual Occup	ation			16b.	Kind of B	usiness/	Industry	
piet	(Specify o	nly highest g	rade completed)			(Give	kind of w	ork done d use retired	during mos	st of work	ing				,	
Completed by Funeral	Elementary/Secondar	y (0-12)	College (			Tree	e Exp	ert				A	rbor	Pro		
O	17. Father's Name (First	, Middle, Las	st)				-		18. Moth	er's Name	e (First, Middle					
To Be	Clyde	Н.		Wa1	l1ace				Luci	nda			Ho1	ston		
-	19a. Informant's Name/	Relationship	(Type, Print)				na Addres	ss (Street	and Numb	er or Rura	ıl Route Numb	er. City				
	Clyde H. Wa	allace	(I	athe	er)						len Bur					
	20a. Method of Disposit				20b. Pla	ce of Disponentery, cre	osition (Na	ame of other plac	(e)	C	Date	20c.	Location -	City or	Town, State	
	1 ☐ Burial 2 【☐ Cr 1 ☐ Donation 5 ☐			State		vijew	Crem	ator	y	3/04			1tim	•		
	21. Signature of Fund	Service Lic	ansie d	m	wh	2	2. Name a MC 32	Cully Cully O4 Mc	ss of Facili y—Pol ounta	ynial in R	k Funer oad, Pa	al sad	Home ena.	p.A Md.	21122	
	23a. art1. Enter the di shock, or heart fai											ırrest,			Approximate Interval Betwe Onset and De	en ath
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r	resulting in dealing		Due to	(or as a	conseque	nce of):										
ē	Sequentially list condition if any, leading to immediate	ons,	b. — Sue to	(ur as a c	ounseque	nea of):										
Examiner	if any, leading to immedicause. Enter Underlying Cause (Disease or injur that initiated events	9 <b>1</b>														
Exa	resulting in death) Last		Due to	(or as a	conseque	nce of):										
dicail			d													
edic			· ·													
by Physician/M	IF FEMALE: 23b. Was decedent pre-	onant	23c. If yes, ou										23d. Da	te of deli	verv	
Cia	in the past 12 mon	ths?			☐Fetal d ne of dea		∃Ectopic p ∃Other (s	pregnancy						onth	Day Yea	ar
Jys	9 Unknown		9□ Unkr	iown												
I d	Part II. Other significan	t conditions	contributing to c	leath but	not result	ing in the u	inderlying	cause give	en in Part I	l.	23e. Did	obacco	use cont	ribute to	the cause of dea	th?
											10	Yes :	2 🗆 No	3 🗆 Pro	babiy 4 (Uni	nown
ete											24a. Was		Oah I	Mass	tanau findings au	- Inhlo
Completed										<del></del>	auto perfe	psy ormed?	240.	death?	topsy findings ava ompletion of caus	se of
0	25. Was case referred t	o medical							26 Dlane	e of Death	1 XYes	2□N	0	Yes	2 No	
0 0	examiner? 11 Yes 2 No		Hospital:	Inpatient	∌/¥⊏¤	R/Outpatier	nt 3 D	OA Othe	ar:		me 5∐ Resi		6 1704	or /C		
-	27. Manner of Death					8b. Time o		28c. Injury	4 □ Nt	-	me 5∟ Hesi 28d. Describe				iry)	
tification:	1 Natural 5 2 ☐ Accident	Pending investigati		ith, Day Y	(ear)	Injury	м	Work	k? Yes 2□				., -50411			
tifle	3 ☐ Suicide 6 4 ☐ Homicide	Could not determine	209. Place	of Injury	· At hom	e, farm, st	reet, factor	ry, office			28f. Location (	Street a	ind Numb	er or Ru	ral Route Numbe	r,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Medical Cel State

30. Name and address of person who completed cause of death (Item 23a) (Type. Print) 111 Penn Street, Baltimore, Maryland 21201 RUB10, 31. Date filed (Month, Day, Year) Registrar MAR 0 8 2004

29b. Signature and title of certifier

29a. Certifier

MD 32. Registrar's Signature

oaks/

Undertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

224Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 4, 2004

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month MATEL Edward W. Wisniewski 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale If Under 24 Hrs. BALtimore HOSPITAL CENTER FRANKLIN Squere If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Months Days 1 JM 2 □ F Hours Min 213-18-7504 81 こるしないの Director 25,1922 MAryland April Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD Baltimore Essex 1 Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 800 George Ave. 21221 USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ✓ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify:White þ 3 Widowed 4 Divorced than "netural", Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Whiting&Turner Millwright 8th s 1 and 2 should be filed vit Health and Mental Hygie item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanislawa Popincka Joseph Wisniewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Wisniewski 9318SevenCourtsDrive PerryHallMD /son 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. N Burial 2 ☐ Cremation 3 ☐ Removal from State SacredHeartofJesus 3/9/04 Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licens 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENCEPHAL OPA Thy
Due to (or as a consequence of): **Physician** /Medical **Examiner** POG Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed 212 physician Box 68760 reumon? A Physician/Medical the ! IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ٦ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 DNo Be Completed INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 2□ No 1 ☐ Yes 1 TYes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 ☑ No this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) I in by t 4 Homicide pelly the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN Square DRIVE BALtimore Med 2/237 GRUNR MOININGS. R 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature Registrar MAR 0 8 2004

		-	For State Registrar	State of Marylar		artment of H rtificate of L			<sup>ene</sup> 200	4 0	169	83
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Y	ear	Time of [	
	Physici: /Medic	al	Anthony Philli	-	fer Sr			Month 3	3 200		:00	P M
1	Examin	er	4a. Facility Name (If not institution, give st			4b. City, Town, or		th	4c. County of			
			550 Cleveland Roa  5. Social Security Number 6. Sex	7. Age (in yrs.	(act hirthday)	Linthic	um If Under 24 Hrs	8. Date of Birth	Anne A	rundel Birthplace		Foreign
	Funeral Director			M 2□F 80	Yrs.	Months Days	Hours Min.		Year)	Country)	MD	1 Graigir
		t	Usual Residence of Decedent									
	how		10a. State 10b. County		ty, Town or Lo						nside City	•
	Ba-f s	cto	MD Anne Arun	idel Li	nthicu						Yes	ZX_1NO
	vith th	Dire	10e. Street and Number	ī		10f. Zip Code	000	10	g. Citizen of Wha			
	s 23s	ral	550 Cleveland Road	Was Decedent Ever in U	10 12 1		090	Specify Ves or No-		USA American In	ndian	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, I'm Madical Evantrer must be rivillied at anone.	by Funeral Director	11. Marital Status  1 Never Married 2 🛣 Married  3 Widowed 4 Divorced	Armed Forces?  1 X Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	Specify:	to Rican, etc.)		White, etc. whit		
Maryland 21215-0036	tural tural	ed b	15. Decedent's Educ		16a. Dece	dent's Usual Occupa	ation		8b. Kind of Busin	ness/Industry	у	
5	n "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wo	orking				
212	d with	Eo	11	College (1-401 34)	Su	perintend	ant		Constr	uction	1	
힏	al Hy 1 other	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, M				
<u>ya</u>	ould b Ment arked atic e	ဥ		lallnofer			Christi	<u> </u>				
Jar	2 sh and is m		19a. Informant's Name/Relationship (Type Mrs. Florence Wall					u <i>ral R</i> oute Nu <i>mber.</i> Lnthicum M	-	ate, Zip Code	θ)	
e,	1 and Health em 27 ther t		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of			20c. Location - Cit	ty or Town, S	State	
Baltimore,	nt of h	١.	1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, crei	matory`or other plac emerCemet			Baltimor			
語	artme artme prtant injury	1	*4 ☐ Donation 5 ☐ Other (Specify)  21. Signature — neral Service (icense)					ingleton l				
a	Per Per Per Per Per Per Per Per Per Per	10	> / mulla	MO136				Glen Burni				
	Physician /Medical Examiner	J.	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a consec	Quence of):	Per the mode of dyin	g, such as cardia	c or respiratory arre	st,	Inte	proximate prval Betw set and D	ween
68760,	icate be executed physicien and s the burial-transit	edical Examiner	fl any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec								
.O. Box (	that the death certific: ed by the attending pl detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	,	Y	/ear
<u>α</u>	es ngi es		Part II. Other significant conditions conditions	tributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribu	ute to the car		
Records,	و ڪ و	Completed by						24a. Was ar autops perform 1 Yes 2	prio	re autopsy fi or to complet uth?	tion of ca	
Vital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one				
of <	Physician: this certific ral director.	10	1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐			4 U Nursing	Home 5 Reside		(Specify)		
o uc	ding P h. After t funera	lon:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	_	28d. Describe ho	w injury occurred			
Division	or Attendent fler deat pirector: n by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci			Yes 2 □No	28f. Location (Sti City or Town		o <i>r Rural R</i> ou	ute Numi	ber,
ت	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	dical Ce	(Check only 2/ Medical Examin	sician: To the best of my kn par: On the basis of examin	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the ca curred at the time, da	use(s) and mann ite and place, and	er as stated.	cause(s)	)
	thin 2 the the mplet	Med	29b. Signature and title of certifer	and manner stated.		29c. Licens	e number	29	d. Date signed (	Month, Dav	Year)	
<b>•</b>	F 3 F 8		· RIII						3/11/21	' <u>.</u>		
	h		30. Name and address of person who con	moleted cause of death (Ite	m 23a) (Tvne	Print)	3700		19/04			
	9		Dul pot Cinel	Colle 1	613 H	mustali	Korel	# 106	oder	ton 101	11) 21	1117
16.	Sta Regist	ate rar	31. Date filed (Month, Day, Year) (MAR 0 8 2004	32. Registrar's Sign	ature from	w	- 404	11				

		1 - For State Registrar	State of Maryland	/ Department of H Certificate of I	Death	Reg. (	_	06984
Physici /Medic Examir	cal	4a. Facility Name (First Middle, Last)	JACHING Je	4b. Cing Town, or	r Location of Death	030	Year Ac. County of Death N/A	3. Time of Death
Funeral Director		5. Social Security Number 6. Sex 1 212-84-0353 Usual Residence of Decedent	M 25x 44	Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes 1 2 - 0 2 - 1 9		elace (State or Foreign ntry) RYLAND
within 72 hours after death with the Maryland jiene. I than "neturel", or items 23s or 28s-f ehow the Medical Evariliser must be notified at	il Director	10a. State 10b. County  MD N/A  10e. Street and Number		BALTIMORE  10f. Zip Code			Citizen of What Cour	0d. Inside City Limits  1 ☐ Yes 2 ☐ No  Attry?
hours after death	d by Funeral	1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 24 No	Specify:	offy Yes or No- lican, etc.)		etc. LACK
ad within 72 rgiene.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occup. (Give kind of work done of life. DO NOT use retired.  CASHI	during most of working	g	Kind of Business/Ind  SUPERMAR:	ŕ
2 should be and Mental is marked o	To Be	THOMAS WASHING	oe, Print)	19b. Mailing Address (Street a	CECELIA and Number or Rural	A NICHOI Route Number, City	JSON y or Town, State, Zip	Code)
Pages 1 arment of Healant: If Item;		SHELIA WASHING'  20a. Method of Disposition  1 Burial 2 Ocremation 3 DR  4 Donation 5 Other (Specify)	emoval from State 20b. Place ceme		θa Υ 03-08	1	STOWN Location - City or To	1D 21133 wn, State
pernait. Departition of the pernait.		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	Cations that caused the death.	22. Name and Address  4600 LiB  Do not enter the mode of dyin	HOV ERTY HGH	r AVE, E	IERAL HOI	ME MD 21207 Approximate Interval Between Onset and Death
/Medical Examiner  whysician and purial-transit the prinal-transit the	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, lea ling to mm-diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent Due to (or as a conse	em Organ mundlefic ice of:	neng VI	NUS		4 days
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8 <u>8</u> 8	by	Part II. Other significant conditions con	tributing to death but not resultin	ng in the underlying cause give	en in Part I.	23e. Did tobacco	use contribute to th	e cause of death?  ably 4 Unknown
The law ate has b page 2 s	e Completed	25. Was case referred to medical			26. Place of Death	24a. Was an autopsy performed? 1 Yes 2	prior to cor death?	osy findings available npletion of cause of 2 No
. S S	cation; To B	27. Manner of Death  1 Natural 5 Pending investigation		/Outpatient 3 DOA Other b. Time of Injury Mork M 1 1	er: 4 🗆 Nursing Hom		6 □Other (Specify ury occurred	')
in the	sal Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	dge, death occurred at the tim	ne date and place, an	City or Town, Sta	c) and manner as et	atad
Λ	Medical	(Check only 2 Medical Examirone)  29b. Signature and title of certifier	ner: On the basis of examination and manner stated.	and/or investigation, in my op	oinion, death occurred	d at the time, date a	nd place, and due to	the cause(s)
(b)	ite	30. Name and address of person who co	mpleted cause of death (Item 23	Sa) (Type, Print) Hospi	And of	Both	Moro	-/

Physici /Medi		<ol> <li>Decedent's Name (First, Mid</li> </ol>	dle, Last)			artment of dificate of			. Date of De			3. Time of Death
		Linda Ellen	Walls-Gill	Liam					Janua:	-	2004	08:38 A
Examir	er	4a. Facility Name (If not institute		_		4b. City, Town,		7 -			County of Death	
Francis		300 Webb Lane 5. Social Security Number	Apartment	7. Age (In yrs. la	ast birthday)	If Under 1 Yea		er 24 Hrs. 8.	. Date of Bir	th 1/24	Talbot 1/1955 <sub>9. Birthi</sub>	place (State or Forei
Funeral Director		220-68-8582	1□ M 2∭ F	49	Yrs.	Months Day	s Hours	Min.	an 2/1	y, Year) 19	54 Mary	ntry) land
3		Usual Residence of Decedent  10a. State 10b. Coun	lv .	10c. City	, Town or Lo	ocation						10d. Inside City Limi
28a-f ahow	ō	MD Tal	•	,		Michael'	S					1 ☐ Yes 2 <b>)</b>
r 28a	Director	10e. Street and Number				10f. Zip Code				10g. Citi	izen of What Cou	ntry?
ms 23a or	aiD	300 Webb Lan	e #C-2			216	63				USA	
	Funerai	11. Marital Status	Armed Fo		3. 13.	Was Decedent of If Yes, specify Cu	Hispanic ( ban, Mexic	Origin? (Specif can, Puerto Ric	y Yes or No can, etc.)	)-	<ol> <li>Race - Americ Black, White,</li> </ol>	
ural, or its	by F	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 🛣 Divorce	If Vac Gi	ve		1 ☐ Yes 2X No	Specif	fy:			Specify: wh	nite
natural dical Ex			ent's Education rest grade completed)		16a. Dece	dent's Usual Occi	upation	ost of working		16b. Ki	ind of Business/In	dustry
198	Completed	Elementary/Secondary (0-12 1 2			life.	DO NOT use retir	ed)	odi or working				
yg t	Co	17. Father's Name (First, Middle			d1	sabled	18. Mot	ther's Name (F	First, Middle	Maiden	none	
of Health and Mental Fitam 27 is marked of	To Be		iel George					Carolin				
and M a mar	-	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailin	ng Address (Stree	at and Num	iber or Rural R	Route Numb	er, City o	r Town, State, Zip	Code)
n 27 l		Kathy Longley	/sister			Goldsbor	ough		-	on, l	MD 2160	1
Department of Heali Important: If itam 2 any injury or other once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☒ Other,		State Ce	ace of Dispo metery, crei	sition (Name of matory or other pl	ace)	Date	a	20c. Lo	ocation - City or To	own, State
Departrumporta Importa any inju		21. Signature of Euneral Server ROTTal Id	S. Wade I	Director	S	Name and Additute Ana 11timore	ess of Fac tomy	Board 6	655 W.	Ba1	Ltimore S	Street
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y the attending physician and iched for use as the burial-transit	edicai	that initiated events	c. Due to d. 23c. If yes, out 1 □ Live b.	(or as a consequence of pregnar of the come of pregnar of the come of the com	ence of):	Ectopic pregnan	су			2	23d. Date of delive Month	ery Day Year
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n. After this certificate has been signed by the attending phys funeral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  Part II. Other significant conditions of the examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pend investigations of the existence of the examiner of the examiner? 2 Accident 3 Suicide 6 Coul	c. Due to d.  23c. If yes, out 1 Live be 4 Pregreged Unknown tions contributing to do do to be 28e. Place 28e. Place	come of pregnanion and at time of decown  eath but not result inpatient 2 E E of Injury	ence of):  hecy death 3 [ ath 5 [  itting in the unitary  ER/Outpatien 28b. Time of Injury	other (specify)  nderlying cause g  st 3 DOA  28c. Inju	26. Plather: 4 1 h	ce of Death (C	24a. Was autor performed to the control of the cont	obacco u Yes 2[ an ssy immed? 2 \sum No one) dence 6 now injury	Month  Ise contribute to the No 3 Prob  24b. Were autored agains?  1 Ses  5 Vector (Specify occurred)	Day Year  ne cause of death?  pably 4 Aunknov  psy findings availat  mpletion of cause of  2 No  SCENE
n. After this certificate has been signed by the attending phys funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to d.  23c. If yes, out 1 Live to 4 Pregray Unknown tions contributing to do do to be ling and to be mined 28e. Place building Physician: To the ball Examiner: On the ba	come of pregnanimith 2 Fetal lant at time of decown  eath but not result inpatient 2 Fetal lant at time of decown  eath but not result inpatient 2 Fetal land land land land land land land la	ence of):  accy death 3 ath 5	other (specify)  Inderlying cause g  Inderlying cause g  Inderlying cause g  Inderlying cause g  Inderlying cause g  Inderlying cause g	26. Plather: 4 1 h	ce of Death /C	24a. Was autoperformed to the control of the contro	obacco u Yes 2[ an Disy rmed? 2 No One) dence 6 now injury Street and	Month  Ise contribute to the second of the s	Day Year  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?
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DHMH 17 Rev 1/2001

ORIGINAL

Amend item # 23a,25, per ME, G835, 9/9/04 TT State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** V501 91 1020AM 2009 /Medical Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Nursin umb19 10619Y one Hours Min. 08-23-1914 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days 1 € M 2 □ F 577-03-9637 89 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours efter deeth with the Merylenc 10a. Stete MD MONTGOMERY SILVER SPRING 1 ☐ Yes 2€XNo Directo rel', or items 23a or 28a-fr Examiner must be notifie 10f. Zip Code 10a. Citizen of What Country? 10e. Street end Number 14709 CLAUDE LANE 20905 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14∑ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: WHITE Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. SELF-EMPLOYED GAS SERVICE STATION other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) RUSSELL ANDERSON PEARL BASSFORD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7057 Mink Hollow Rd. Highland, MD 20777 ALLAN ANDERSON - SON of Heelth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Peges 1 Burial 2 Cremation 3 Removal from State ò FORT LINCOLN Cem. 02-16-04 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility Hines-Rinaldi F.H. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hypertensive atherosclerotic cardiovascular disease **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) CERTIFICATION APPROVED BY MEDICAL EXAMINER PGV Examiner Due to (or as a consequence of) Physiclan/Medical Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, ed by the ettending physiclen deteched for use as the burie Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed by å 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? hes 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Hospitel: Other: 20110 1X Yes 1 🗆 Inpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpetient 3 ☐ DOA After this s efter death.

I Director: After this ad in by the funeral d 28b. Time of 28c. Injury et Work? 27. Menner of Death 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours e To the Funeral C completely filled filled edical 29a. Certifier TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as steted (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Year) 10 of person who completed cause of death (Item 23e) (Type, Print) 30. Name end eddre K9210W 10803 4ic LOV

DHMH 16 Rev 6/95

State

Registrar

31. Dete-filed (Month, Day, Year)

FEB 17

32.

2004

Registrer's Signature

			1 - For State Registrar	State of Maryla	nd / Dep		lealth and N	lental Hy			ΩΞ
	Physic		1. Decedent's Name (First, Middle, Last,	ANDERSON				2. Date of Dea Month FEBRUAR	ath Day	Year 3. Time of Di	
3	/Medi Exami		4a. Fecility Name (If not institution, give			4b. City, Town, o	r Location of Death	FEDRUAR	4c. County		Р
1	ZXXIII		Montgomery Genera	al Hospital		Olney	,		gomery		
	Funeral Director		2.3 2. 23	7. Age ( <i>i</i> n <i>yr</i> s	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) NOV.10		9. Birthplece (State or F Country) 0 h i o	-oreign
	aryland show	2	Usuel Residence of Decedent  10a. State 10b. County  Md . Montgor		City, Town or Lo	nersburg				10d. Inside City	- 2
	ith the M or 28a-f	Funeral Director	10e. Street and Number	iici y		10f. Zip Code			10g. Citizen of V		.⊠NO
	ath w	ral	7304 Rosewood Mai			208				States	
036	n 72 hours after death with the Maryland "nature!", or Itema 23a or 28a-f show solice! Exeminer must be notitited at	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Blac Specify	e - American Indian, k, White, etc. : White	
Maryland 21215-0036	d within 72 ho giene. r than "natur ine Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	16b. Kind of Bu	siness/Industry	
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ylanc	Mental Mental arked o	To Be	17. Father's Name (First, Middle, Last)  Robert Anderso				18. Mother's Name Elizabe	th M	cFarlan	ď	
	s 1 and 2 sho of Health and Item 27 is m other treum		19a. Informant's Name/Relationship (Ty Eva D. Anderson	/ Wife	7304	Rosewood	and Number or Rura Manor La	ne, Gai	thersbu	rg, Md. 208	882
Baltimore,	Page nant: If ury or		20a. Method of Disposition  1 Burial 2 Commation 3 R  4 Donation 5 Other (Specify)			sition (Name of natory or other place itan Crem		Oate 704		City or Town, Stete ria, Virgin	ia
Ball	Departi Import any inj		21. Signature of Funeral Service License  Thuring	1 Barl			ss of Facility Barber F x 5038, L			d. 20882	
	Physician /Medical Examiner		23a. Part1. Enter the diseese, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	OINTE	or the mode of dyin	g, such as cardiac c	or respiratory arr	est,	Approximate Interval Betwee Onset and Dea	ath
8760,	ate be executed hysician and the burial-transit	Ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							
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Vital Records, P	uires that n signed b	d by Pł	Part II. Other significant conditions con			derlying cause give	en in Part I.			bute to the cause of deat	
CO	law requir as been si 2 should	Completed	,,	FT VENTRI		THE ME.	25	24a. Was a	n 24b. W	ere autopsy findings ava	ulable
m m		Com	Hypraentavs			11111796		autops perform	y pr neg? de	ior to completion of caus eath? □Yes 2□ No	e of
/ita	i <b>cian</b> : Th certificate rector, pag	Be (	25. Was case referred to medical				26. Place of Death		<u> </u>		
	Physic this cal	<u>٩</u>	1 ☐ Yes 2 1 No		ER/Outpatient		4   Nursing Hon				
Division of	ding l	Certification;	27. Manner of Death  1 Manner of Death  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		at ? ∕es 2 □ No	8d. Describe ho	w injury occurre	d	
Σ			4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)			City or Town	, State)	r or Rural Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dirc completely filled in	Medical	29a. Certifier 16 Certifying Phys (Check only one) 2 Medical Examin	icien: To the best of my known: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and place, a sinion, deeth occurre	and due to the ca	use(s) and man ate and place, ar	ner as stated. nd due to the cause(s)	
-	1	2	29b. Signature and title of certifier	1		29c. License				(Month, Day, Year)	
	6		30. Name and address per in who con	mpleted cause of death (Item	m 23a) (Type, F		947			19,2004	
F			31. Date filed (Month, Day, Year)	3 416 OL 32. Registrar's Signa	Mouor	o lans	SUITE 20	O OLN	Chen E	20832	
	Sta Registr		FFR 2.0 200		4	Sparks					

State of Maryland / Department of Health and Mental Hygiene 20006988 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** George Wesley Brown February 10 2004 12:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 80 Yrs. Director May 9 1923 Jamaica 578-78**-**3918 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-1 show among any injury or other traumatic event, the Medical Examine trinual by multiple at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 TYes 2 No Maryland Montgomery Burtonsville Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3670 Childress Terrace 20866 Jamaica Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 27 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: Black þ 3√2 Widowed 4 □ Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Chauffer Transportation 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Cornelius Brown Leatrice Gardner 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3670 Childress Terrace, Burtonsville, MD 20866 Rosemarie Brown - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Crematory 2-15-2004 | Brentwood, MD → Other (Specify) Ft. of Funeral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21-Slone 11800 New Hampshire Av., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cŏngestive Heart Failure **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? certificate 1 Yes 2 **X**No To the Hospital or Attending Physician: : After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after usass...

To the Funeral Director: / investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 0053700 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUNIE 207/6 mitchellulle MJ) 3060 ( ITAWLA 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State FEB 1 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month February Miriam Delal Baer 11, 2004 2115 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director 218-68-6044 51 Jan. 30, 1953 Washington, D.C Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f ehow The Medical Examiner must be notified at 1√2 Yes 2 □ No Maryland Montgomery Chevy Chase Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 6815 Delaware Street U. S. A. Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
snt: If Itam 27 ie marked other than "natural", or Items 23. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Mexican American Specialist Political & Economic Elementary/Secondary (0-12) College (1-4or 5+) Relationships ituations of Mexico 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Moses Baer Inge Rosen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn M. Wellspeak - Friend 6805 Florida Street, Chevy Chase, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rosedale Cemetery 2/15/2004 Baltimore, Maryland permit.
Departminents 21. Signature of Funeral Service License Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland Donald 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Widespread Carcomatosis 7 Months resulting in death) /Medical Due to (or as a consequence of): Examiner Leiomyosarcoma of the Uterus Sept. 2002 Sequentially list conditions, One to (or as a consequence of) Examiner any leading to immedia cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Vest Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2√2 No 3 Probably 4 Unknown Completed has been 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 2 🕅 No 1 ☐ Yes or Attending Physician: rector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other 4 Nursing Home 5 Residence SCOther (Specify) Hospice Medical Certification: To 1 ☐ Yes 2 No luneral dir 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <u>a</u> 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 1> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison, M. 6001 Muncaster Mill Road, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar 06990 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** -Month Yeer BALTHIS 1031 AM G. 2004 7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT HEALTHEARE BALTIMOR If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Dec. 2 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 1 M 2 X F Country) Illinois 92 1911 Director 227 46 4331 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Md. Cecil Elkton Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 11 Charles Street or Itams 23a 21921 United States Funeral Peges 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 21 No Specify White ð 3 Widowed 4 ☐ Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than. Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Education Health and Mental Hygi em 27 le marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry G. Standish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 a Department of Health ar Importent: If Item 27 le any injury or other trau 11 Charles Street, Harry G. Balthis, Jr. / Son Maryland Elkton, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 2/18/04 Alexandria, Va. 21. Signature of Funeral Service License <sup>22</sup>Name and Address of Facility
Muriel H. Barber Funeral Home murie P. 0. Box 5038, Laytonsville, Md. 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PSIS Physician Xdays /Medical Due to for as a consequence of): **Examiner** SIGMOID COLON Sequentially list conditions, a year ling to mine lists cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed DIVERTICULITY burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 4☐Pregnant at time of death Month Day Year signed by the a 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform Vital 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) 1 Yes 2 No X atient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 2 ER/Outpatient 3 DOA Division of this 27. Manner of D ath (Month, Day Year) 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause |s| and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the Fune completely fi (Check only within 2 7 the F To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMORE 9 100 GANN MD 2122 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 19 Registrar 2004

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F	lealth and <i>Death</i>	Mental Hy	giene 2	004	06991		
			Decedent's Name (First, Middle, Last)					2. Date of De			3. Time of Death		
	Physicia		Joyce E. Bargamian	1				2-10-2	004 <sup>Day</sup>	Yeer	6:00 A. M		
	/Medic Examin		4a. Fecility Name (If not institution, give si			4b. City, Town, o	or Location of De	ath	4c. Cou	unty of Deeth			
			Forest Glen Nursin	ng Home		Silver				tgomer	·		
	Funeral		Social Security Number     6. Sex	7. Ag M 2⊠F	e (In yrs. last birthday	If Under 1 Year   Months   Days	If Under 24 H Hours Mi	n. (Month, Da	rth ay, Year)		place (State or Foreign htry)		
	Director		051-26-1/15	M ZIZIF	72 Yrs.			10-3-1	931	New	York		
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits		
	lanyli neho	5		_	Cd large Ca						1 ☐ Yes 2 No		
	28a-	ect	MD Montgomery	/	Silver Sp	10f. Zip Code			10g. Citizen	of What Coun	ntry?		
	with Sa or	0	13 David Ct.			20904			U.S.A				
	leath ms 23	Funeral Director		2. Was Decedent	Ever in U.S. 13.	Was Decedent of I	Hispanic Origin?	(Specify Yes or No	o- 14.	Race - Americ			
0	after or Itar		1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 ☒		If Yes, specify Cub  1 ☐ Yes 2 ☑ No	Specify:	eno rican, etc.)		Black, White,			
20.	ral', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		I⊔ fes Zigg No	эрөспу.		Spi	ecity: Whi	Lte		
ה ה	72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Giv	edent's Usual Occur e kind of work done	during most of w	vorking	16b. Kind o	of Business/Ind	dustry		
7	ithin nan "	Jd L	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retire	a)		77				
7	led w tygie har ti		12. Father's Name (First, Middle, Last)		Home	maker	18. Mother's N	ame (First, Middle	Home Maiden Sur	mame)			
yıand	i be fi	Be	John Mc Grury					Elvire		,			
Ž	d Me d Me mark matic	ပ္	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mail	ing Address (Street	and Number or			wn, State, Zip	Code)		
Mar	od 2 s lith an 27 le trau		Albert Bargamian		d 13	David Ct.	Silver	Spring,	MD 209	904			
a)	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Introprent: If Item 27 le marked othar than "natural", or Itams 23a or 28a-1 show any injury or othar traumatic event, the Medical Examinar must be motified at once.	. 72	20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other pla	ce)	Date	20c. Locati	ion - City or To	own, State		
9	Page :: 50		1 🖾 Burial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)	moval from State	Gate of			13-2004	Silve	r Sprin	ng, MD		
pairimor	nat. I		21. Signature of Funeral Service License	θ Α	A	22. Name and Addre			naldi 1	F. H.			
ă	Depar Impor any in		I shrane of	· Coff	silv 1	1800 New	Hampshi	re Ave. S	Silver	Spring	g, MD 20904		
	Physician /Medical Examiner	ner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury)  Due to (or as a consequence of):  Due to (or as a consequence of):										
,00/90	eath certificate be executed attending physician and for use as the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):								
O. Box b	the death certify the attending as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Bc. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d.	. Date of delive Month	ery Day Year		
cords, P	w requires that the death been signed by the atte should be detached for	by P	Part II. Other significant conditions con Atrial Fibrilatio	-	out not resulting in the	underlying cause gr	ven in Part I.				ne cause of death?		
ပ္ပ	law red as bee 2 shor	ompleted	Pulmonary embolis	m				24a. Was	an 2	4b. Were auto	psy findings available		
T T	9 <u>C</u> <u>0</u>	E						perfo	ormed?	death?	mpletion of cause of 2 No		
VITAI	ician: The certificate rector, pag	Se C	25. Was case referred to medical				26. Place of D	eath (Check only	one)				
	is 78	To B	examiner? 1 ☐ Yes 2 🖾 No	ospital: 1 🗌 Inpati	ent 2 ER/Outpatie	ent 3 DOA	ner: 4 🖾 Nursing	Home 5□Res	dence 6	Other (Specifi	y)		
on or	nding Ph ath. r: After th e funeral		27. Manner of Death 1 ★Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	ay Year) 28b. Time Injury	Wo	ryat rk? ]Yes 2 □ No	28d. Describe	how injury oc	curred			
DIVISION	To the Hospital or Attending Ph within 24 hours alter death. To the Funaral Director: After th Completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	jury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, office		28f. Location ( City or To		umber or Rura	d Route Number,		
	To the Hospl within 24 hou To the Funar completely fill	Medicai	29a. Certifier 1 A Certifying Physical Check only one)	ician: To the best er: On the basis of and manner st	of my knowledge, dea of examination and/or i tated.	th occurred at the ti nvestigation, in my	me, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and date and pla	i manner as st ce, and due to	tated. the cause(s)		
	To the year of the Comp	M	29b. Signature and title of centriler			29c. Licens	se number		29d. Date si	gned (Month,	Day, Year)		
•	3(5)		Ha Min	llem		504	5-4		Febu	many,	13,04		
			30. Name and address of person who con										
			Arastoo Yazdani, M		1 Georgia A	Avenue; S	ilver Sp	oring, MD	20902				
	Sta Registi		31. Date filed (Month, Day Year)		rar's Signature	Soork							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200 LFor State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ORGT FEBRUARY 14, 2004 6:15 A M /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MONTGOMERY POTOMAC SUMMERVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day Year 9. Birthplace (State or Foreign Country) PENNSYLVANIA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Director 209-26-2381 68 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show monitory injury or other traumatic event, the Medical Examiner must be notified at once. 28a-f show Director 1 ☐ Yes 2 No FLORIDA PALM BEACH BOYNTON BEACH 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? #102 33437 U.S.A. Funeral 8058 ABERDEEN DR., 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. I ☐ Yes 2 🎇 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 🕅 Divorced WHITE Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ESTHER ROSENBLATT ٩ PERRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8913 CHERBOURG DR., POTOMAC, MD 20854 STUART BARR/SON 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State GARDEN OF REMEMBRANCE 02/16/2004 CLARKSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** WEEKS disease or condition resulting in death) RENAL FAILURE /Medical Due to (or as a consequence of) Examiner 3 MONTHS MULTIPLE MYELOMA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sicien and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy performed? Yes 20 No 1□ Yes 2 No 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) ASSISTED Certification; To 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After LIVING Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Medicai ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier mpletely one) within 2

State Registrar

(31. Date filed (Month.

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Ty --, - Int)

29c-License number

29d. Date signed (Month, Day, Year)

6

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death February 17, 2004 John Lester 12:25 P.M. Barr

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

14. Race - American Indian. Black, White, etc.

Specify: White

February 17, 2004

Birthplace (State or Foreign Country)

10d. Inside City Limits 14 Yes 2 □ No

Approximate Interval Between Onset and Death

Maine

Physician
/Medical
Examiner

4a Facility Name (If not institution, give street and number)

8313 Woodhaven Blvd.

**Funeral** 

Director Funeral Director Completed by Be

permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at Physician /Medical Examiner

attanding physician and for usa as tha bunal-transit The law raquires that the death cartificate be axecuted eral Director: After this cartificate has been signed by the a filled in by the funeral director, page 2 should be deteched Aftar this

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours aftar daath. To the Hospital c within 24 hours al To the Funeral D complataly filled 12

Examiner

Certification: To Be Completed

edical

If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) August 25,1944 Days 11 M 2□ F Months Hours 59 171-36-6261 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location Md. Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8313 Woodhaven Blvd. 20817 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ■ Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Kaiser Permanente Physician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Lester Barr, Jr. Isabelle Ogilby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill H. Barr / Wife 8313 Woodhaven Blvd. Bethesda, Md. 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Feb.18, ALexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Furniral Service L 22. Name and Address of Facility DeVol Funeral Home 2222 Wisc. Ave., N.W. Wash.D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) Cell Cancer of the Kidney 18 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Cause (Disease or injury that initiated events resulting in death) Last	c Due to (d	or as a consequence of	):		
Part II. Other significant conditions co	ontributing to death but not res	sulting in the underlying	cause given in Part I.	23b. Did tobacco use co	ontribute to the cause of death?
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
					1 Yes 2LINO
25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐	3500	Othor	eath (Check only one)	
	28e. Date of Injury		JOA 4 ☐ Nursing 28c. Injury at	Home 5 Residence 6 □Oth  28d. Describe how injury occur	ner (Specify) rred
27. Manner of Death  1 DNetural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		Injury M	Work? 1 ☐ Yes 2 ☐ No		
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h	ome, farm, street, facto	ry, office	28f. Location (Street and Numi	ber or Rural Route Number,

City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and granner stated. 29a, Certifier

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of forson who completed cause of death (Item 23e) (Type, Print)

Wesley Mason, M.D. 10810 Connecticut Ave., Kensington, Md. 20895

State Registrar 31. Date filed (Month, Day, Year) 20 FEB

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar 06994 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day RAUDINO Year ROSALIND SHIELDS 20 A M EBRUARY 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNAPOLITAN ASSISTED LIVING ANNAPOLIS ANNE ARUNDEL 8. Date of Birth (Month, Day, Year) 9. Birthplace (Country) November 1,1910 Pennsylvania 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 2XX Days Hours Director 215.50.6167 93 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits Item 27 ie marked other then "natural", or Items 23a or 28a-f eho: other treumatic event, II a Medical Examinar must be notified at 1 Yes 2 No Director MD Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9620 Accord Drive 20854 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 222No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after Hygiene, ther then "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No White Specify: 3 XWidowed 4 □ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Pages 1 and 2 should be filed venent of Health and Mental Hygies ont: If Item 27 Ie marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ည Dennis Shields Ellen Doran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Hartsock/ Daughter 9620 Accord Drive Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite injury or 1XX Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2/20/04 Silver Spring, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue NW WDC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed on that initiated events resulting in death) Last Due to (or as a consequence of) attending physicien a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed 1 Yes 2 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To 2XXNo Hospital: Other: 4 Nursing Home 5 Residence 6 No ther (Specify) A L Facili, L 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural To the Hospitel or Attendio within 24 hours after death. To the Funeral Director: A 1 🗌 Yes 2 No the f 6 ☐ Could not be 3 ☐ Suicide I in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) N 30. Name and address of person who com, eted cause of death (Item 23a) (Type, Prin Meelical Group Groffin USAIREB 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryland	d / Depa	artment of F	lealth and I	Mental Hygid	ene 200	4 06995	
	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last)     GEORGE W. BE     4a. Facility Name (If not institution, give st     Shady Grove Advent	_			r Location of Death	2. Oate of Death Month February	Day Yea 11 200	4   22:17 M	
ů.	Funeral Director		5. Social Security Number  229 52 2913  Usual Residence of Decedent	7. Age (In yrs. la	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Dec. 14,	<sup>(ear)</sup> 94 0	Birthplece (State or Foreign Country) Vinginia	
	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28a-f ehow tha Modical Examinar must be nutified at	Director	10a. State 10b. County  Md. Montgom  10e. Street and Number  10015 Shelldrake C			20872	1 -	g. Citizen of What	•		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show many plury or other treumatic event, the Modical Extending Investigate an once.	by Funeral Director		2. Was Decedent Ever in U.S Amed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spin, Mexican, Puerto		United S  14. Race - Ar Black, WI Specify:	merican Indian,	
Maryland 21215-0036	led within 72 ho lygiene. her than "natur. nt, the Mouleell	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed)  College (1-4or 5+)	(Give i	OO NOT use retired	during most of world)	king	Farming		
yland	should be filed and Mental Hygis marked other umatic event, II	To Be	17. Father's Name (First, Middle, Last) George Washingto				Neely	Guy			
e, Mar	f and 2 sh Health and Im 27 ie n Her treun		Phillip L. Bentley,	Sr. / Son	1200	1 Piedmor	nt Road,	ral Route Number, C Clarksbu	rg, Md.	20871	
Baltimore,	permit. Pages in Department of Himportant: If its eny injury or ot once.		20a. Method of Disposition  1) Surial 2 ☐ Cremation 3 ☐ Rei  4 ☐ Donation 5 ☐ Other (Specify)	Lay	tonsv	sition (Name of eatory or other plac ille Cem	. 2/1	6/04 L	aytonsvi		
Ba	Deparmit Depar Impor eny in		21. Signature of Funeral Service Licensee	Barker		P. 0. Bo	0x 5038,	Funeral H Laytonsvi	11e, Md.	20882	
i de	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ACUTE MYOCAF	RDIAL			or respiratory arrest	,	Approximate Interval Between Onset and Death Minutes	
#s;	Examiner	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	CORONARY ART	TERY D	ISEASE				Years	
,09/	ate be executed hysician and the burial-transit	ical Examiner	that initieted events resulting in death) Last  C. Due to (or as a consequence of):								
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ecords, P	The faw requires that the te has been signed by th vage 2 should be detached.	þ	Part II. Other significant conditions contri	ibuting to death but not result	ing in the un	derlying cause give	en in Part I.			to the cause of death?  Probably 4 Minknown	
Vital Heco	(G TT	e Completed	25. Was case referred to medical				GC Plans of Deat	24a. Was an autopsy performed 1 Yes 2 km	prior to death?	autopsy findings available completion of cause of	
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DIVISION	i Dife	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	t and Number or F Itate)	Rural Route Number,	
	승수 교육	edical	29a. Certifier 12 Certifying Physic (Check only one)	cian: To the best of my knowler: On the basis of examination and manner stated.	edge, death n and/or inve	occurred at the timestigation, in my op	e, date and place, inion, death occurr	and due to the caused at the time, date	e(s) and manner a and place, and du	is stated. le to the cause(s)	
	Vithin 2. To the complete	Σ	29b. Signature and title of certifier	Sola	N	29c. License	332	1-1	Date signed (Mor	11, 2004	
			30. Name and address of person who com WILLIAM DOOLEY, M				RIVE, ROC	CKVILLE, M	1D. 2085	0	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 7 2004	32. Registrar's Signatur	B	Sparks	1				

			1 - For State Registrar	State	of Maryland	d / Depa <i>Cei</i>	artment ortificate	of He	ealth and M Death	lental Hy	giene 2	004	06996
П			1. Decedent's Name (First, Midd	fle, Last)						2. Date of De	ath		3. Time of Death
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)	Examir		4a. Facility Name (If not institution	on, give street and n	umber)		4b. City, To	wn, or	Location of Death			nty of Death	
			Montgomery Hospice- Casey House Rockville							Мо	ntgome	ery	
63"	Funeral Director		5. Social Security Number 579-34-3337	6. Sex 1⊠ M 2□ F	7. Age (In yrs. In 74	ast birthday) Yrs.	If Under 1 Months E	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept.	th Year) 3, 1929		place (State or Foreign ntry) as
	p ,		Usual Residence of Decedent  10a. State 10b. Count		ton Cin	, Town or Lo							
	aryia ehov	5											10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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Ore	Pages 1 nent of H unt: If Ite		20a. Method of Disposition 1   Burial 2 □ Cremation	3 Removal from		ace of Dispo metery, cren	sition (Name natory or othe	or er place,	March	2,	20c. Locatio	n - City or To	own, State
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r			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that t only one cause on	caused the death each line.	. Do not ent	er the mode o	of dying,	, such as cardiac o	or respiratory a	rrest,		Approximate Interval Between
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	13.		30. Name and addre s of per to		-		,			1			
			Joseph Kaplan N		Muncast		11 Road	d, I	Rockville	, MD	20855		
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		-	For State	State of Mai	ryland /	Departr Certifi	ment of H icate of I	lealth and r Death	Mental H	ygiene Reg. No	2001	06997
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	Examin		4a. Facility Name (If not institution, give stre				. City, Town, or	Location of Death	n		. County of Deat	
		14"	2715 University B					er Spring			lontgome	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last i	Mo	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	(Month, L	Day, Year)		hplace (State or Foreign untry)
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	and w	}	Usual Residence of Decedent  10a, State 10b. County		10c. City, To	own or Location	on					10d. Inside City Limits
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	ltern Item	Funeral Director	11. Marital Status  1 Never Married 2 Married	Armed Forces? 1 ⊠Yes 2 □ No				ispanic Origin? (S n, Mexican, Puert	o Rican, etc.)		Black, Whit	
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yland	Ald by Alenta rked rked	ToE	Charles Boice					Marg	aret Ma	thew	son	
ary	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  a marked other than "natural", or Items 23a or 28e-f show le marked other than "natural", or Items 23a or 28e-f show are marked other than "natural".		19a. Informant's Name/Relationship (Type	, Print)	1	9b. Mailing A	ddress (Street	and Number or Ru	ıral Route Nun	nber, City	or Town, State, 2	Zip Code)
Mar	alth alth 27 I		Richard Joy/ Nephev	J.	,			town Roa				
e e	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rer	moval from State	20b. Place ceme	of Disposition of the o	on (Name of any or other plac	e) Feb	Date ruary	20c. L	ocation - City or	Town, State
Ĕ	Page His File		*4 □Donation 5 □Other (Specify)	novar nom state	Metro	opolita	an Crema		004	Ale	xandria	, Virginia
saitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, tra Peolical Examinar must be notified at once.		21. Signature on Funeral Service Licensee			22. Na F <b>r</b> a	ame and Addre	ss of Facility 20	Funer	al Ho	ome Inc.	
מ	805 8		(inches) S	-Cole		500	Univers	sity Blvd	1.W., S	ilver	Spring	,MD 20901
			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	ions that caused to	the death. D	o not enter th	ne mode of dyin	g, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Coronary								Years
	/Medical		resulting in death)	Due to (or as a								
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o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		. 0_0.						
<b>1</b>	that the by detail		Part II. Other significant conditions conti	ributing to death bu	t not resultin	g in the unde	rlying cause giv	en in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?
Records,	The law requires that te has been signed b page 2 should be deta	d by							1 (	Yes 2	. No 3 □ P	obably 4 Unknown
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<b>=</b>	ysician: iis certific director,	Be	25. Was case referred to medical examiner?	spital:		/Outpatient	aC DOA Oth	26. Place of De			6 ☐Other (Spe	aiful
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UQ	ding Phy h. After thi funeral	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury		rk?  Yes 2 □ No				
2	l or Attending after death. Director: After I in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Inju	ıry - At home	, farm, street	, factory, office					ural Route Number,
	after after Dire	Certification:	4 Homicide	building, etc	. (Specify)				City of	Town, Stat	9)	
	spite	aiC	29a. Certifier 1 ☑ Certifying Physi	cian: To the best of	of my knowle	dge, death or	curred at the tie	me, date and place	e, and due to the	he cause(s	s) and manner a	s stated.
	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	edicai	(Check only 2 Medical Examinations)	er: On the basis of and manner sta		and/or inves	tigation, in my o	ppinion, death occi	urred at the tim	ie, date an	nd place, and due	to the cause(s)
	To th To th Somp	Me	29b. Signature and title of certifier	11			29c. Licens				ate signed (Moni	
r	7.		Sunte +	+	~	and	- D4	3272		F	ebruary	17, 2004
			30. Name and address of person who con	npleted cause of de	eath (Item 23	Ba) (Type, Pri	nt)					
			Sunita Hanjura M.					#111, Ro	ockvill	e, M	20854	
	St	ate	31. Date filed (Month, Day, Year)		ar's Signature	4	Spark	1,				
	Regist	rar	FFB 1 8 200	A CONTRACTOR	1	6	acional	11				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year Phillip Gillette Brown February 2004 13, /Medical 4:00 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4301 Garrett Park Road Silver Spring Montgomery If Under 24 Hrs.
Hours Min.

8. Date of Birth (Month, Day, Year)
Sept. 2, 1952

9. Birthplace (State or A Country)
Washington, 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days 1X M 2□ F Months 579-62-9543 51 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other treumstic event, the Medical Exercities man be notified. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 1X Yes 2 □ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4301 Garrett Park Road 20906 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify. þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Videographer Video 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Blake C. Brown ဥ Maxine Gillette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bess Brown (sister) 1044 Evergreen Farm Circle, Waynesville, NC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2/17/04 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave. N.W., Washington, D.C. 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical cardiovascular disease a. Atherosclerotic Examiner Due to (or as a consequence of): Examiner signed by the attending physician and d be detached for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. The law requires that the death certificate be Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No certificate 1 ☐ Yes 1□Yes 2 No the Hospital or Attending Physician: thin 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1⊠Yes 2□ No Other: 4 Nursing Home Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) After this illed in by the funeral 27. Mapher of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1. Natural 2 Accident 1 TYes 2 TNo Director: / 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

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completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) attucia oms 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar EB18

2004

32. Registrar's Signature

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/Medio		Richard Arthur					February	1	2004 nty of Death	8:45	р₩
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		Carriage Hill  5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	Bethes If Under 1 Year	If Under 24 H			ot gomer	lace (State o	r Foreigr
Funeral Director		089−10−3400	M 2□F 85	Yrs.	Months Days	Hours M	in. (Month, Day, Oct. 22,		New New	York	
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and 2		Jennifer Brown Gree	Daughter	Washi	ington, D	.C. 20	015				
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ithe death certific by the attending p ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	3c. If yes, outcome of pregnar 1	death 3[	□Ectopic pregnancy □ Other (specify) _				Date of delive	Day	Year
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ding h. Afte fune	tlon	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury		k? Yes 2 □ No					
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To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	Medical C		sician: To the best of my knowner: On the basis of examinational and manner stated.								s)
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(0		30. Name and address of person who consume Susan J. Miller, 1  31. Date filed (Month, Day, Year)		lip H		ce, Bet	hesda, Md	208	316		

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	aryland ehow	٦c	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
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36	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural" or items 23a or 28a-f ehow event, the Medical Examinational be mailled at	by Funeral	4407 Holter Coun  11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Deced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes. Give			755 of Hispanic Oricuban, Mexican No Specify:		Yes or No- an, etc.)		American Indian, White, etc. 'hite		
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			30. Name and address of person who Ronald Miller M				Print) Airy,	MD 217	7 1					
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